Please fill out the Patient Registration Form Below

First Name:_____ Last Name_____ Date of Birth:_____ Sex Male/Female

Preferred Language: _____ Race: _____ Ethnic Group: Hispanic/Latino or Not Hispanic/Latino

Preferred Phone Number: _____ Circle Type: Home/Mobile/Work

Alternative Phone Number: _____ Circle Type: Home/Mobile/Work

Would you like to receive a phone call or text message appointment reminder? ☐ Text Message ☐ Phone Call

Is it OK to leave a detailed voicemail? ☐ YES ☐ NO

Email Address: _____

Street Address: _____ City / State: _____ Zip _____

Emergency Contact Name: _____ Phone Number _____

Health Insurance

Name of Health Insurance(s): _____

Insurance I.D.# _____

Policy Holder Name: _____

Policy Holder D.O.B. _____

Preferred Pharmacy

Name: _____ Phone Number: _____

Address: _____

Referring Provider (if applicable)

Name: _____ Specialty: _____

Phone Number: _____

Primary Care Physician

Name: _____

Phone Number: _____

Please list with whom we may discuss any medical condition or appointment detail. (First & last name, relation to patient)

_____ _____

_____ _____

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1. Do you have any of the following medical problems (check all that apply)?

- ○ Anxiety
- ○ Arthritis
- ○ Asthma
- ○ Atrial fibrillation
- ○ Bone marrow transplant
- ○ BPH (prostate enlargement)
- ○ Breast cancer
- ○ Colon cancer
- ○ Coronary artery disease
- ○ Depression
- ○ Diabetes
- ○ End stage renal disease
- ○ GERD (GI/reflux)
- ○ Hearing loss
- ○ Hepatitis (liver disease)
- ○ Hypertension (high blood pressure)
- ○ HIV/AIDS
- ○ Hypercholesterolemia (high cholesterol)
- ○ Hyperthyroidism (overactive thyroid)
- ○ Hypothyroidism (underactive thyroid)
- ○ Leukemia (blood cancer)
- ○ Lung cancer
- ○ Lymphoma
- ○ Prostate cancer
- ○ Radiation treatment
- ○ Seizures
- ○ Stroke
- ○ Other: _____
- ○ No known past medical problems

2. What surgeries have you had?

_____

_____

_____

3. Do you have any of the following skin problems (please check all that apply)?

- ○ Acne
- ○ Actinic keratoses (precancerous lesions)
- ○ Asthma
- ○ Basal cell skin cancer
- ○ Blistering sunburns
- ○ Dry skin
- ○ Eczema
- ○ Flaking or itchy scalp
- ○ Hay fever/Allergies
- ○ Melanoma
- ○ Poison ivy
- ○ Precancerous moles
- ○ Psoriasis
- ○ Squamous cell skin cancer
- ○ Other: _____
- ○ No known skin issues

4. Do you wear sunscreen?

- ○ Yes – What SPF? _____
- ○ No

5. Do you tan in a tanning salon?

- ○ Yes
- ○ No

6. Has anyone in your family had melanoma?

- ○ Yes – Who? _____
- ○ No
- ○ Unknown

7. What medications do you take?

_____

8. Do you have any allergies?

- ○ Yes – Please list: _____
- ○ No

9. Have you ever smoked cigarettes or other tobacco products?

- o No, never
- o Yes, but not anymore
  - o When did you start?

    _____
  - o When did you quit?

    _____
  - o Total years you smoked?

    _____
  - o How many packs per day?

    _____
- o Yes, currently
  - o Daily
  - o Occasionally cigarettes
  - o Occasionally other tobacco products
  - o Cigars

10. Do you use drugs?

- o Yes
- o No

11. How much alcohol do you drink?

- o None
- o Less than 1 drink per day
- o 1 – 2 drinks per day
- o 3 or more drinks per day

12. What is your occupation?

_____

13. What medical problems are in your family?

Mother _____
Father _____
Brother(s) _____
Sister(s) _____
Grandmother(s) _____
Grandfather(s) _____
Aunt(s) _____
Uncles(s) _____
Other _____

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Do you have any of the following (please check all that apply)?

- ○ Problems with bleeding
- ○ Problems with healing
- ○ Problems with scarring (hypertrophic or keloid)
- ○ Rash
- ○ Immunosuppression
- ○ Hay fever
- ○ Chest pain
- ○ Fever or chills
- ○ Night sweats
- ○ Unintentional weight loss
- ○ Thyroid problems
- ○ Sore throat
- ○ Blurry vision
- ○ Abdominal pain
- ○ Bloody stool
- ○ Bloody urine
- ○ Joint aches
- ○ Muscle weakness
- ○ Neck stiffness
- ○ Headaches
- ○ Other: _____
- ○ NONE