

**New Patient Registration Information**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_/\_\_\_/\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_ Preferred? □ Messages? □

Mobile Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_ Preferred? □ Messages? □

Work Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_ Preferred? □ Messages? □

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Referring Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Provider/Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Effective date:** \_\_\_\_\_\_\_\_

**Policy Holder:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Do you know a recent:** Weight\_\_\_\_\_ Height \_\_\_\_\_\_\_ Blood Pressure \_\_\_\_\_\_\_\_\_\_

**Medications:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Indicate which of the following you have been diagnosed with or treated for in the past:**

Acid Reflux: □ Anxiety: □ Arthritis: □ Asthma: □ AFib (Irregular Heartbeat): □

Bone Marrow Transplantation: □ Breast Cancer: □ Colon Cancer: □ COPD: □

Coronary Artery Disease: □ CTCL: □ Depression: □ Hearing Loss: □ HIV: □

Hepatitis: □ High Cholesterol: □ High Blood Pressure: □ Hyperthyroidism: □ Hypothyroidism: □ Leukemia: □ Lymphoma: □ Mycosis Fungoides: □ Prostate Cancer: □ Radiation Treatment: □ Seizures: □ Stroke: □ Other: □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prior surgeries (check all that apply):**

Appendix: □ Bladder: □ Breast, Lumpectomy: □ Breast, Mastectomy: □

Colon Cancer: □ Colon, Diverticulitis: □ Colon, Inflammatory Bowel Disease: □

Gallbladder: □ Heart, valve replacement: □ Heart, Bypass: □ Heart Transplant: □

Joint Replacement: □ Kidney, Transplant: □ Kidney, Nephrectomy: □ Liver, Transplant: □ Liver, other: □ Ovaries: □

Pancreas: □ Testicles: □ Uterus: □

Other: □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin Disease History (check all that apply):**

Abnormal Moles (Dysplastic Nevi): □ Acne: □ Actinic Keratosis: □

Blistering Sunburns: □ Eczema: □ Hay Fever: □ Psoriasis: □

Basal Cell Carcinoma (BCC): □ Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When?\_\_\_\_\_\_\_\_\_\_\_\_

Squamous Cell Carcinoma (SCC): □ Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When?\_\_\_\_\_\_\_\_\_\_

Melanoma (MM): □ Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_

Merkel Cell Carcinoma: □ Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_

Uses Sunscreen: □ What SPF?:\_\_\_\_\_\_ Current/Past Tanning Bed use?:\_\_\_\_\_\_

**Family History (chronic illnesses in grandparents/parents/siblings/children):**\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History of Skin Cancer (BCC, SCC):** □ **Family History of** **Melanoma:** □ Who?\_\_\_\_\_\_\_\_

**Social History (check where appropriate):**

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Smoking: Current: □ PPD:\_\_\_\_ Never: □ Former: □ Year Quit: \_\_\_\_\_

Alcoholic Beverages: □ # per day: \_\_\_\_\_

Drives in the daytime: □ Drives at night: □ Exercise: □ How often?: \_\_\_\_\_\_\_\_\_\_ Caffeine use: □ How often?:\_\_\_\_\_\_\_\_\_\_

Comments: