COLORADO CENTER for DERMATOLOGY & SKIN SURGERY

# Patient Registration Form

Today's Date: ______________

| Patient's Last Name | First Name (as it appears on insurance card or ID) | Middle Name |
|---|---|---|
| | | |

| Nickname | Date of Birth (MM/DD/YYYY) | Sex |
|---|---|---|
| | | |

| Preferred Language | Race | Ethnic Group |
|---|---|---|
| | | |

| Mobile Phone | Home Phone | Work Phone |
|---|---|---|
| | | |

| Email Address | Preferred Phone: ☐ E gZad ☐ @ge ] ☐ O gjc | Preferred Method of Contact: ☐ Phone ☐ Email ☐ Patient Portal |
|---|---|---|

Home Address (inc. Apt. #)

| City | State | Zip Code |
|---|---|---|
| | | |

| Seasonal Address: | Is Mail Forwarded? ☐ Yes ☐ No<br>Dates: |
|---|---|

| Occupation | Employer/School | Employer/School Phone |
|---|---|---|
| | | |

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other:

| Spouse's Name | Phone | Spouse's Occupation/ Employer |
|---|---|---|
| | | |

| Emergency Contact Name | Emergency Contact Phone | Relation to Patient |
|---|---|---|
| | | |

| Caretaker Name | Phone |
|---|---|
| | |

## Responsible Party / Guarantor (If other than patient)

| Name | Date of Birth | Relation to Patient |
|---|---|---|
| | | |

| Address | City | State | Zip |
|---|---|---|---|
| | | | |

| =e Yad | H` gf] ☐ Mobile ☐ Home ☐ Work |
|---|---|

## Referral Information (Please check below to help us determine how you heard about our office)

☐ Physician ☐ Friend ☐ Relative ☐ Insurance ☐ One of Our Patient's ☐ Our Website ☐ Prior Patient ☐ Referral Service

☐ Internet (specify search engine): ______________ ☐ Other: ______________

| **Referring Physician**<br>Name, Address | Phone Number |
|---|---|
| **Primary Care Physician**<br>Name, Address | Phone Number |
| **Preferred Pharmacy**<br>Name, Address inc. City & Zip | Phone Number |
| **In-Network Lab** | Phone Number |

## Information Release

Do you give our office permission to discuss your medical information with family members, including but not limited to: biopsy results, blood / lab results, or other test results? ☐ Yes ☐ No If, YES:

| Name | Relationship | Phone Number |
|---|---|---|
| | | |

<g qgm _an] our office permission lg d Yn] \] lYad\ e ]kkY_]k Yl qgmj hj] ^]jj]\ h`gf] fme Z]j j]_Yj\af_ Yfq l]klk l` Yl qgme Yq af[mj Yk Y hYlq]fl$af[dm\af_ Zml fgl dae al]\ lg2Zaghkq j]kmdlk$ZdggÉ dYZ j]kmdlk$gj gl`]j l]kl j]kmdlk7 ☐ **Yes** ☐ **No**

**Signature** (Patient or Legal Representative) ______________ **Date** ______________

*Last Revised: Mar 8, 2020*

COLORADO CENTER for DERMATOLOGY & SKIN SURGERY

# Patient Health History Form

Full Name

Today's Date

DOB

## Reason for Visit

## Medical Alerts

Do you develop keloid scars? (firm, thick, scars) ☐ Yes ☐ No

Do you bleed easily? ☐ Yes ☐ No If yes, are you on blood thinners? ☐ Yes ☐ No

Do you have an artificial heart valve? ☐ Yes ☐ No

Have you had Artificial Joints in the last 2 years? ☐ Yes ☐ No

Do you have a Defibrillator or Pacemaker? ☐ Yes ☐ No

Do you have history of MRSA infection? ☐ Yes ☐ No

Do you require antibiotics prior to procedures? ☐ Yes ☐ No

Do you develop rapid heartbeat to epinephrine (e.g., EpiPen)? ☐ Yes ☐ No

## Past Medical History

Have you ever had any of the following?

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ BPH (Enlarged Prostate)
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Heart Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Acid Reflux)
- ☐ Hearing Loss
- ☐ Heart Valve Replacement
- ☐ Hepatitis
- ☐ HIV/ AIDS
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Joint Replacement
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Stroke
- ☐ **NONE**

Other:

## Hospitalizations & Surgeries Use more space as needed (or attach list).

Reason Date

Reason Date

## Women Only

Are you pregnant, breastfeeding, or planning to become pregnant? ☐ Yes ☐ No

## Skin History

Have you ever had any of the following:

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Basal Cell Carcinoma
- ☐ Blistering Sunburn
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaky/Itchy Scalp
- ☐ Hay Fever/ Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma

During your visit today, would you like to learn about skin care treatments and/ or products to optimize the health and appearance of your skin? ☐ Yes ☐ No

If you have had skin cancer (basal cell, squamous cell, or melanoma), please provide additional details:

Year? Body location?

How was it treated?

Do you regularly apply sunblock to exposed areas? ☐ Yes ☐ No

If yes, which SPF? Is it zinc-based? ☐ Yes ☐ No

Have you visited tanning salons or do you sunbathe? ☐ Yes ☐ No

Do you have family history of Melanoma? ☐ Yes ☐ No

If yes, which relative?

## Current Medications Use more space as needed (or attach list).

List all medications you are currently taking (including prescriptions, vitamins, herbals, over-the-counter,and birth control pills or devices).

| Name | Dosage | Frequency |
|---|---|---|
| Name | Dosage | Frequency |
| Name | Dosage | Frequency |
| Name | Dosage | Frequency |
| Name | Dosage | Frequency |

## Allergies Use more space as needed (or attach list).

Are you allergic to any of the following?

- ☐ Adhesive Tape
- ☐ Codeine
- ☐ Penicillin
- ☐ Aspirin
- ☐ Sulfa
- ☐ Cephalexin
- ☐ Latex
- ☐ Lidocaine
- ☐ Clindamycin

Do you have any other allergies?

| Name | Reaction |
|---|---|
| Name | Reaction |

## Social & Other (REQUIRED)

Have you ever smoked?

☐ Yes ☐ No # of years # packs/day

Do you smoke now?

☐ Yes ☐ No # packs/day

Do you use recreational drugs?

☐ Yes ☐ No types? # times/week

Have you ever received the pneumonia vaccine?

☐ Yes ☐ No

Do you have a **Healthcare Proxy** in the event you cannot make your own medical decisions? ☐ Yes ☐ No

Do you have a **Living Will**? ☐ Yes ☐ No

## Family History

Has anyone in your family ever had any of the following conditions?

- ☐ Abnormal Moles
- ☐ Acne
- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin Cancer (NOT Melanoma)
- ☐ Other:

**Signature** (Patient or Legal Representative)

*Last Revised: Mar 8, 2020*