COLORADO CENTER for DERMATOLOGY & SKIN SURGERY

Annual Information Update*

Today's Date: ____________________

Patient's Name	DOB (MM/DD/YYYY)

Occupation

*Please review your facesheet demographics at check-in and note any changes to address, telephone, email, marital status, emergency contact, primary care provider, preferred pharmacy, etc. Thank you.

Responsible Party / Guarantor (if other than patient)

Name	DOB	Relation to Patient	
Address	City	State	Zip
=e Yad	H` gf]	☐ Mobile ☐ Home ☐ Work	

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 g Yn] \]lYad\ e]kkY_]k Yl qgmj hj]^]jj]\ h` gf] fme Z]j j]_Yj\af_ Yf q l]klk l` Yl qgm e Yq af[mj Yk Y hYla]fl$ af[dm\af_ Zml fgl dae al]\ lg2 Zagh kq j]kmdlk$ Zdgg\ ' dYZ j]kmdlk$ gj gl`]j l]kl j]kmdlk7 ☐ Yes ☐ No

Current Medications Not Previously Reported to Our Office
Use more space as needed (or attach list).

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

Name	Dosage	Frequency	Name	Dosage	Frequency
Name	Dosage	Frequency	Name	Dosage	Frequency
Name	Dosage	Frequency	Name	Dosage	Frequency
Name	Dosage	Frequency	Name	Dosage	Frequency

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

Were you admitted to the hospital or did you have any surgeries in the last year? ☐ Yes ☐ No If yes, please describe:

Reason	Date	Reason	Date

Allergies Not Previously Reported to Our Office
Use more space as needed (or attach list).

Are you allergic to any of the following?

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

Do you have any other allergies?

Name	Reaction
Name	Reaction

Social & Other (REQUIRED)

Have you ever smoked/used tobacco?
☐ Yes ☐ No # of years ____________ # packs/day ________

Do you smoke/use tobacco 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

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