COLORADO CENTER for DERMATOLOGY & SKIN SURGERY

Portal Supplement Form

Today's Date: _____

Patient's Full Name	Date of Birth (MM/DD/YYYY)	Preferred Phone ☐ Qsfmi ☐ Lsqi

Home Address (inc. Apt. #)	City	State	Zip Code

Occupation	Employer/School	Employer/School Phone

Marital Status ☐ Single ☐ Married ☐ Other:	Spouse's Name	Spouse's Phone	Spouse's Occupation/ Employer

Responsible Party / Guarantor (if other than patient)

Name	DOB	Relation to Patient

Address	City	State	Zip

Iqep	Tlsri ☐ 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 Name, Address	Phone Number
Primary Care Physician Name, Address	Phone Number
Preferred Pharmacy 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

Hs }sy kmzi our office permission xs piezi hixepih qiwwekiw ex }syv tvijiwih tlsri ryqfiv vikevhmrk er} xiwxw xlex }sy qe} mrgyv ew e texmirx0 mrgpyhmrk fyx rsx pmqmxih xs> fmstw} viwypxw0 fpssh 3pef viwypxw0 sv sxliv xiwx viwypxwC ☐ Yes ☐ No

Skin History

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

Have you had any of the following skin cancer types? (check all that apply)

Cancer Type	Year	Body Location	Treatment
☐ Basal Cell Carcinoma			
☐ Squamous Cell Carcinoma			
☐ Melanoma			

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? _____

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

Any medications not entered into portal 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

Any allergies not entered into portal Use more space as needed (or attach list).

Name	Reaction

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

Last Revised: Mar 8, 2020