

Today's Date: _____

Patient's Full Name		Date of Birth (MM/DD/YYYY)	Preferred Phone <input type="checkbox"/> [E.g. 303] <input type="checkbox"/> [Area Code]	
Mailing Address (inc. Apt. #)		City	State	Zip Code
Occupation	Employer/School	Employer/School Phone		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other:	Spouse's Name	Spouse's Phone	Spouse's Occupation/ Employer	

Responsible Party / Guarantor (if other than patient)

Name	DOB	Relation to Patient		
Mailing Address (inc. Apt. #)	City	State	Zip	
Home Phone	Cell Phone	<input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> 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
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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
<input type="checkbox"/> Basal Cell Carcinoma	_____	_____	_____
<input type="checkbox"/> Squamous Cell Carcinoma	_____	_____	_____
<input type="checkbox"/> Melanoma	_____	_____	_____

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

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? _____

Any medications not yet 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).

If none, please check here:

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

If none, please check here:

Name	Reaction
_____	_____
_____	_____