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)

	DOB	Relation to Patient	
Mailing Address (inc. Apt. #)	**City**	**State**	**Zip**
Email	**Phone**		
	☐ 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

Do you give our office permission to leave detailed messages at your preferred phone number regarding any tests that you may incur as a patient, including but not limited to: biopsy results, blood / lab results, or other test results?

☐ **Yes** ☐ **No**

Medications & Allergies 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).

If none, please check here: ☐

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

Are you allergic to any of the following?

If none, please check here: ☐

☐ 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**

Last Revised: January 8, 2021