COLORADO CENTER for DERMATOLOGY & SKIN SURGERY

Patient Registration Form

Today's Date: _____

Patient Information

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: ☐ Mobile ☐ Home ☐ Work

Preferred Method of Contact: ☐ Phone ☐ Email ☐ Patient Portal

Mailing Address (inc. Apt. #)

City	State	Zip Code

Seasonal Mailing Address (inc. Apt. #)

Is Mail Forwarded? ☐ Yes ☐ No

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/Caretaker Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient
Caretaker Name	Phone ☐ Mobile ☐ Home ☐ Work	

Responsible Party / Guarantor (If other than patient):

Name	Date of Birth	Relation to Patient	
Address	City	State	Zip
Email	Phone ☐ 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 include City & Zip)	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

Do you give our office permission to leave detailed messages at your preferred phone number regarding any tests you may occur as a patient, including but not limited to: Biopsy results, Blood/lab results, or other test results? ☐ **Yes** ☐ **No**

_____ _____

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

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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?

- ☐ **NOT APPLICABLE**
- ☐ 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
- ☐ Seizures
- ☐ Stroke

Other: _____

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

Reason _____ Date _____

Reason _____ Date _____

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

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 have a family history of melanoma? ☐ Yes ☐ No

If yes, which relative? _____

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

If yes, which SPF? _____

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

Social & Other (REQUIRED)

Have you ever smoked/used tobacco?

☐ Yes ☐ No # of years _____

Do you smoke/use tobacco now?

☐ Yes ☐ No # packs/day _____

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

Have you ever received the pneumonia vaccine? ☐ Yes ☐ No

If Age 12-14:

Have you had 2 HPV (Human papillomavirus) vaccines? ☐ Yes ☐ No

Have you had your TDap (Tetanus, Diphtheria, Pertussis) vaccine? ☐ Yes ☐ No

Have you received your Meningococcal vaccine? ☐ Yes ☐ No

Women Only

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

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).

If none, please check here: ☐

I consent to having my medication history digitally imported from my pharmacy, health plans, and other healthcare providers. ☐ Yes ☐ No

Name	Dosage	Frequency

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

Are you allergic to any of the following? **If none, please check here:** ☐

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

Do you have any other medication allergies? **If none, please check here:** ☐

Name	Reaction

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: Jan. 1, 2026