COLORADO CENTER for DERMATOLOGY & SKIN SURGERY

Annual Information Update*

**Please review facesheet at check-in to note changes to address, phone, email, marital status, emergency contact, PCP, preferred pharmacy, etc. Thank you.*

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

Occupation

Responsible Party /Guarantor (if other than patient)

Guarantor Name | DOB | Relation to Patient

Mailing Address (inc Apt #) | City | State | Zip

Email | Phone ☐ Mobile ☐ Home ☐ Work

Detailed Messages

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 & History Use more space if needed or attach list

List all new medications you are currently taking that you **have not previously reported to our office** (including prescriptions, over-the- counter, vitamins, herbals, and birth control pills or devices).

If no changes, please check here: ☐

Name | Dosage | Frequency

Name | Dosage | Frequency

Name | Dosage | Frequency

Name | Dosage | Frequency

I consent to having my medication history digitally imported from my pharmacy, health plans, and other healthcare providers.

☐ Yes ☐ No

Allergies

Since your last visit, do you have any **new** medication, adhesive tape, or latex **allergies**?

If no changes, please check here: ☐

Name | Reaction

Name | Reaction

Name | Reaction

Women Only (REQUIRED)

Are you pregnant, breastfeeding, or planning to become pregnant?

☐ Yes ☐ No

Since your last visit, any changes to your medical history (conditions, surgeries, hospitalizations)? Please describe below.

If no changes, please check here: ☐

Social & Other (REQUIRED)

Have you ever smoked/used tobacco?

☐ Yes ☐ No # of years

Do you smoke/use tobacco now?

☐ Yes ☐ No # packs/day

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

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

POLICIES & ACKNOWLEDGMENTS

☐ I acknowledge and will comply with the information contained within the practice's **Office Policies**. I understand that these policies are subject to change without prior notice and that I may request a copy of the current policies at any time.

☐ I acknowledge and consent to the information contained within the practice's **Notice of Privacy Practices**. I understand that these policies are subject to change without prior notice and that I may request a copy of the current policies at any time.

Signature Patient or Legal Representative

Date

Print Name of Signer