ANTHONY DEE, MD PLLC
DERMATOLOGIC CENTER FOR EXCELLENCE

PATIENT REGISTRATION FORM Date_____

Patient Name:_____DOB:_____Sex: ☐M ☐F
Address:_____
City/State/Zip:_____
Email:_____Social Security #:_____
Please provide contact information and *indicate your preferred contact number*:
☐Home Phone:_____ ☐Cell: _____
May we leave a message? ☐Y ☐N May we text you to confirm appointments? ☐Y ☐N
Employer:_____Occupation:_____Phone:_____
Pharmacy Name:_____Phone:_____
Primary Care Physician: _____
Referred By:_____
Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Ethnic Group
- ☐Hispanic or Latino
- ☐Not Hispanic or Latino
- ☐Decline

Race
- ☐White
- ☐African American
- ☐American Indian or Alaska Native
- ☐Asian
- ☐Native Hawaiian or Pacific Islander
- ☐Other Race

Emergency Contact:_____Relationship:_____Phone:_____
Minor patient's parent/guardian name:_____Phone:_____
Who is *financially* responsible for patient? _____
Address, if different from patient:_____

PRIMARY INSURANCE INFORMATION

Insurance Company:_____
Policy Holder:_____Relationship to patient:_____
Policy Holder DOB:_____

SECONDARY INSURANCE INFORMATION

Insurance Company:_____
Policy Holder:_____Relationship to patient:_____
Policy Holder DOB:_____

TERTIARY INSURANCE INFORMATION

Insurance Company:_____
Policy Holder:_____Relationship to patient:_____
Policy Holder DOB:_____

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PATIENT INTAKE FORM

Patient Name_____ Date of Birth_____ Date_____

Chief complaint today: _____

_____

Select any of the following medical conditions that you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (irregular heartbeat)
- ☐ Bone Marrow Transplantation
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension/High Blood Pressure
- ☐ Hypercholesterolemia/High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ None
- ☐ Other_____

Please list any past surgical procedures and dates: _____

_____

_____

Do any of the above procedures require that you take an antibiotic before the dentist (premedicate)? Yes No

Have you had any of the following skin conditions?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Carcinoma
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma** When? _____
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma
- ☐ Other_____ _____
- ☐ None

Do you wear sunscreen? ☐ Yes ☐ No

If yes, what SPF? _____

Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have an *immediate* family history of melanoma? ☐ Yes ☐ No

If yes, which relative(s)? _____

Do you drink alcohol? (**REQUIRED**)

- ☐ None
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day

Do you smoke? (**REQUIRED**)

- ☐ Never smoked
- ☐ Former smoker
- ☐ Current every day smoker
- ☐ Current some day smoker

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Patient Name_____ Date of Birth_____ Date_____

Please list any medications you are currently taking, including over-the-counter:

Medication	Dose	Frequency	Date Started

Are you allergic to any medications? ☐ Y ☐ N If yes, please list: _____

_____

For new patients only: Are you experiencing difficulty ***today*** with any of the following:

- ☐ Problems with bleeding
- ☐ Problems with healing
- ☐ Problems with scarring (hypertrophic/keloid)
- ☐ Rash
- ☐ Immunosuppression
- ☐ Anxiety
- ☐ Depression
- ☐ Muscle Weakness
- ☐ Unintentional Weight Loss
- ☐ Thyroid Problems
- ☐ Sore Throat
- ☐ Blurry Vision
- ☐ Abdominal Pain
- ☐ Bloody Stool
- ☐ Chest Pain
- ☐ Fever or Chills
- ☐ Night Sweats
- ☐ Headaches
- ☐ Seizures
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Joint Aches
- ☐ Muscle Aches

Alerts: Do you have any of the following?

- ☐ Allergy to adhesive
- ☐ Allergy to lidocaine
- ☐ Allergy to topical antibiotic ointments
- ☐ Artificial heart valve
- ☐ Artificial joints within past two years
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ MRSA
- ☐ Pacemaker
- ☐ Premedication prior to procedures
- ☐ Rapid heartbeat with epinephrine
- ☐ Pregnancy or planning a pregnancy