## WELCOME TO SOUTH COAST DERMATOLOGY INSTITUTE

Please fill out the information below, which remains strictly confidential. ***PLEASE PRINT CLEARLY***

NAME: (PATIENT) ______________________________ DATE: ____________
Last First M.I.

GENDER: M / F DOB: ____________ AGE: ________ MARITAL STATUS: ____________

DRIVER'S LICENSE #: ________________ EMAIL: ______________________

ADDRESS: ____________________________________________
Street City State Zip Code

PHONE: Home ______________ Work ______________ Mobile ____________

PREFERRED PHONE/VOICEMAIL CONTACT: Home / Work / Mobile

EMPLOYER: ____________________ OCCUPATION: ____________________

HOW DID YOU HEAR ABOUT US? __________________ REFERRING DR. ____________

Has a friend/family member ever been a patient? If yes, name and relationship: ______________

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**SUBSCRIBER INFO:** (If not self, please provide responsible party information)

NAME: ______________________________________ DOB: ____________

RELATIONSHIP TO PATIENT: ________________ DRIVER'S LICENSE #: ____________

ADDRESS: ____________________________________________
Street City State Zip Code

PHONE: Home ______________ Work ______________ Mobile ____________

INSURANCE: ______________ SUBSCRIBER #: ____________ GROUP #: ____________

PHARMACY: ____________________________________________
Name of Pharmacy Street Address, City Phone Number

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## MEDICAL HISTORY INTAKE

**PAST MEDICAL HISTORY:** *(Please circle all that apply)*

Anxiety
Arthritis
Artificial Joints
Asthma
Atrial Fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss

Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Other ____________________
Valve Replacement

**PAST SURGICAL HISTORY:** *(Please circle all that apply)*

| | |
|---|---|
| Appendix Removed | Kidney Biopsy |
| Bladder Removed | Kidney Removed ( Right, Left) |
| Mastectomy (Right, Left, Bilateral) | Kidney Stone Removal |
| Lumpectomy (Right, Left, Bilateral) | Kidney Transplant |
| Breast Biopsy (Right, Left, Bilateral) | Ovaries Removed: Endometriosis |
| Breast Reduction | Ovaries Removed: Cyst |
| Breast Implants | Ovaries Removed: Ovarian Cancer |
| Colectomy: Colon Cancer Resection | Prostate Removed: Cancer |
| Colectomy: Diverticulitis | Prostate Biopsy |
| Colectomy: IBD | TURP |
| Gallbladder Removed | Skin Biopsy |
| Coronary Artery Bypass | Basal Cell Cancer Surgery |
| PTCA | Squamous Cell Carcinoma Surgery |
| Mechanical Valve Replacement | Melanoma Surgery |
| Biological Valve Replacement | Spleen Removed |
| Heart Transplant | Testicles Removed (Right, Left, Bilateral) |
| Joint Replacement, Knee (Right, Left, Bilateral) | Hysterectomy: Fibroids |
| Joint Replacement, Hip (Right, Left, Bilateral) | Hysterectomy: Uterine Cancer |
| Joint Replacement within last 2 years | Other ________________________________ |

**SKIN DISEASE HISTORY:** *(Please circle all that apply)*

| | |
|---|---|
| Acne | Flaking or Itching Scalp |
| Actinic Kerartoses | Hay Fever / Allergies |
| Asthma | Melanoma |
| Basal Cell Skin Cancer | Poison Ivy |
| Blistering Sunburns | Precancerous Moles |
| Dry Skin | Psoriasis |
| Cold Sores | Squamous Cell Skin Cancer |
| Eczema | Other: ______________________________ |

Do you wear Sunscreens? Yes No
If yes, what SPF? _________________________________
Do you tan in a tanning salon? Yes No

Family history of Melanoma? Yes No
If yes, which relative(s)? ___________________
Any other family history: _______________

**Medications**:
______________________________________________________________________________
______________________________________________________________________________

**Allergies:** ______________________________________________________________________

**Social History:** *(Please circle all that apply)*

| Alcohol Use: | Cigarette Smoking: | Pregnancy: |
|---|---|---|
| Alcohol: None | Never Smoked | Never Pregnant |
| Alcohol: Socially | Quit: Former Smoker | Planning Pregnancy |
| Alcohol: 1-2/day | Smokes socially | Previous Pregnancy |
| Alcohol: 3+/day | Smokes daily | Currently Pregnant |
| | Vapor User | Breastfeeding |

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I understand that I am responsible for any or all of the monies not paid by my insurance including copays. I will notify this office of any changes in the above information. I hereby authorize South Coast Dermatology Institute to furnish to insurance carriers information concerning my illness and treatments, and I hereby assign to South Coast Dermatology Institute all payments for medical services rendered to myself and/or my dependents. I authorize the use of this signature on all my insurance submissions. I acknowledge that I have reviewed the Notice of Privacy Policies.

_____________________________ _____________________________ _______________________ ______________
SIGNATURE: PATIENT and/or RESPONSIBLE PARTY/INSURED RELATIONSHIP DATE