GREENVILLE DERMATOLOGY

PATIENT INFORMATION FORM (please print)

Social Security Number _____

Full Name: _____ Nickname: _____
(first) (middle) (last)

Birthdate: _____ Age _____ Male _____ Female _____

Street _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

E-mail _____ Communication Preference: Home Cell E-mail Postal Mail

Occupation _____ Employer _____

Referring Physician _____ Primary Physician _____

Marital Status _____ Married _____Divorced _____Single _____Widowed _____Separated

Preferred language _____ Race _____ Ethnicity _____ Prefer not to answer _____

Spouse Information

Name _____DOB _____

Phone Number _____ SSN _____ Spouse's Employer _____

Parent Information (Complete Only if Minor or Student)

Father's Name _____ Employer _____ Phone _____

Social Security Number _____ DOB _____

Mother's Name _____ Employer _____ Phone _____

Social Security Number _____ DOB _____

Person Responsible for Medical Bills

Name _____ Address _____

Primary Insurance _____ Secondary Insurance _____

Insurance & Fee Policy

I understand that I am personally responsible for payment of all fees for professional services rendered by this office unless other arrangements have been made in advance. I also authorize Greenville Dermatology, LLC to release my insurance company any information concerning my healthcare, for the purpose of processing insurance claims. I understand the privacy notice for Greenville Dermatology, LLC.

_____ _____

Patient/Legal Guardian *Date*

HEALTH AND MEDICATION INFORMATION

Patient Name_ _____

Preferred Pharmacy? _____

***Alerts*:**

- ☐ Allergy to adhesive
- ☐ Allergy to lidocaine/Xylocaine/Adrenalin
- ☐ Allergy to topical antibiotics
- ☐ Allergy to Rubber or Latex
- ☐ Artificial heart valve
- ☐ Artificial joint placement
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ MRSA
- ☐ Pacemaker
- ☐ Require antibiotics prior to surgical procedure
- ☐ Rapid heartbeat with epinephrine
- ☐ Are you pregnant or currently trying to get pregnant

***Past and Present Health Conditions*:**

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

Circle any Other Conditions: Acid Reflux; ADD/ADHD; Bleeding/Blood Disorder; Blood Transfusion; Epilepsy/Nerve Disease; Heart Disease; Kidney Disease; Lung Disease; STD's; Stomach/Intestinal Disease; _____

Past Surgical History

- ☐ Appendix Removed (Appendectomy)
- ☐ Bladder Removed (Cystectomy)
- ☐ Breast Biopsy __ Right __ Left
- ☐ Lumpectomy __ Right __ Left
- ☐ Mastectomy __ Right __ Left

Colon Removed (Colectomy)

- __ Colon Cancer Resection
- __Diverticulitis
- __ Colostomy

- ☐ Gallbladder Removed

Heart

- __ Biological Heart Valve Replacement
- __ Coronary Artery Bypass Surgery
- __ Heart Transplant
- __ Mechanical Valve Replacement

Joint Replacement

- Hip __Right __ Left
- Knee __ Right __ Left

Kidney

- __ Biopsy __ Stone Removal
- __ Transplant __ Nephrectomy

Liver

- __ Hepatectomy (removed) __ Shunt
- __ Transplant

Ovaries

- __ Endometriosis __Ovarian Cancer
- __ Ovarian Cyst __ Tubal Ligation

- ☐ Pancreas Removed (Pancreatectomy)

Prostate Removed (Prostatectomy)

- __Biopsy__Cancer__TURP__Removed

- ☐ Rectum: Low Anterior Resection

Continued on back

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Skin

__ Basal Cell __ Melanoma
__ Skin Biopsy __ Squamous Cell

☐ Spleen Removed (Splenectomy)

☐ Testicals Removed __ Left __Right

Uterus Removed (Hysterectomy)

__ Fibroids __Uterine Cancer
__ Cervical Cancer

☐ None

☐ Other

List other Surgeries: _____

***Skin Disease History*:**

☐ Acne
☐ Actinic keratosis
☐ Asthma
☐ Basal cell skin cancer
☐ Blistering sunburns
☐ Dry skin
☐ Eczema
☐ Flaking or itchy scalp
☐ Hay fever/allergies
☐ Melanoma
☐ Poison ivy
☐ Precancerous moles
☐ Psoriasis
☐ Squamous cell skin cancer
☐ None

***Other skin conditions*:** atypical moles; fever blisters; large scares; keloids; scalp condition;
_____

Do you use sunscreen? ___Yes ___No SPF ___

Do you currently use tanning beds __Yes __No

List all prescription and non-prescription medicines you are now taking:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you have any drug allergies? ___Yes ___No
(If yes, please list allergy & reaction)

_____
_____

***Social History*:**
Do you currently smoke? ___Yes ___No
Were you a former smoker? ___Yes ___No
When did you quit smoking**?** _____
Do you drink alcohol? • Yes • No

Family History (Only first degree relatives only: mother, father, sister, brother, grandparents)

_____Cancer	Who: _____	Type: _____
_____Cholesterol	Who: _____	Type:_____
_____Diabetes	Who: _____	Type: _____
_____Heart Disease	Who: _____	Type: _____
_____High Blood Pressure	Who: _____	Type: _____
_____Kidney Disease	Who: _____	Type: _____

Patient Initials: _____