



**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:

- 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:

- 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

- Past Surgical History: Appendix Removed (Appendectomy), Bladder Removed (Cystectomy), Breast Biopsy, Lumpectomy, Mastectomy, Colon Removed (Colectomy), Gallbladder Removed, Heart, Joint Replacement, Kidney, Liver, Ovaries, Pancreas Removed, Prostate Removed, Rectum: Low Anterior Resection

Continued on back

**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:**

- |                                                 |                                                    |
|-------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Acne                   | <input type="checkbox"/> Hay fever/allergies       |
| <input type="checkbox"/> Actinic keratosis      | <input type="checkbox"/> Melanoma                  |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Poison ivy                |
| <input type="checkbox"/> Basal cell skin cancer | <input type="checkbox"/> Precancerous moles        |
| <input type="checkbox"/> Blistering sunburns    | <input type="checkbox"/> Psoriasis                 |
| <input type="checkbox"/> Dry skin               | <input type="checkbox"/> Squamous cell skin cancer |
| <input type="checkbox"/> Eczema                 | <input type="checkbox"/> None                      |
| <input type="checkbox"/> Flaking or itchy scalp |                                                    |

**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)

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\_\_\_\_\_

**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:** \_\_\_\_\_