

PATIENT REGISTRATION FORM**PATIENT – Reason for Visit?** _____**Last Name:** _____ **First Name:** _____ **MI:** ____**DOB:** _____ **Referred by (Dr. X, Angie's List, friend, etc.):** _____**Pharmacy (Name/City/Street Name):** _____ **SSN:** _____**Please circle one of the following:** Married Single Divorced Widowed Separated**Race/Ethnicity:** Asian American Indian or Alaska Native Native Hawaiian or Other Pacific
Black or African American White Hispanic Other Other Pacific Islander***Home Phone:** (____) _____ **Cell Phone:** (____) _____**Work Phone:** (____) _____ **Email:** _____**Home Street Address:** _____**Home City, State, Zip:** _____**Employer or School:** _____ **Title:** _____**Emergency Contact:** _____ **Phone:** (____) _____**Emergency Contact's Relationship to Patient:** _____

Check all that apply:

OK to leave medical information with Emergency Contact _____ **Voicemail:** _____**OK to leave biopsy results with Emergency Contact** _____ **Voicemail:** _____**OK to leave medical information on patient's voicemail;** _____**If you are OVER 18, you do not need to fill this out and can simply check this box** **RESPONSIBLE PARTY (Policy Holder on Insurance): Relationship to Patient:** _____**Last Name:** _____ **First:** _____ **MI:** ____**Sex:** M or F **DOB:** _____ **SSN:** _____**Home Phone:** (____) _____ **Cell Phone:** (____) _____**Work Phone:** (____) _____ **Email:** _____**Home Street Address:** _____**Home City, State, Zip:** _____

PLEASE FILL IN THE CIRCLES COMPLETELY ON THE BUBBLE SHEET

CORRECT:



INCORRECT:



History of Present Illness

- Itching: Yes No
Duration: Up to a month 1-6 months 6+ months
Tender skin lesion(s): Yes No
Have any lesions been bleeding: Yes No
New or changing lesion(s): Yes No

Past Medical History

Personal history of the following (select all that apply):

- Eczema Hayfever Asthma
Diabetes: Yes No
Atypical nevi(Precancerous mole): Yes No
Personal history of melanoma: Yes No
History of skin cancer: Yes No
Artificial Valves/Joints: Yes No
Pacemaker/Defibrillator: Yes No
AIDS/HIV: Yes No
Currently Pregnant: Yes No
Bleeding Disorder: Yes No

Patients age 65+ that received the Pneumococcal Vaccine (pneumonia): Yes No

Family History

First degree relative with melanoma: (Parent or Sibling) Yes No

First degree relative with the following (select all that apply):

- Eczema Hayfever Asthma

Social History

How often did you have a drink containing alcohol in the past year:

- never (0 points) monthly or less (1 point)
 2 to 4 times a month (2 points) 2 to 3 times a week (3 points)
 4 or more times a week (4 points) 6 or more times a week (4 points)

Are you a: current smoker former smoker never smoker

If yes how many per day: 1-2/day 3-6/day 7-10/day 10+/day

Do you:

- Exercise: Yes No
Use Sunscreen: Yes No
Use sunscreen every day: Yes No
Tanning bed use: Yes No

Review of Symptoms

- Fever: Yes No
Sore throat: Yes No
Joint pain: Yes No