Minnesota DERMATOLOGY

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**: _____

****ANYONE NOT LISTED AS AN EMERGENCY CONTACT WILL NOT BE ABLE TO ACCESS ANY MEDICAL INFO, APPT INFO OR COMMUNICATE ON PATIENT'S BEHALF****

Emergency Contact 1: _____ **Phone**: (_____)_____

Emergency Contact's Relationship to Patient: _____

Emergency Contact 2: _____ **Phone**: (_____)_____

Emergency Contact's Relationship to Patient: _____

Check all that apply:
OK to leave medical information with Emergency Contact(s) _____ **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: O Yes O No
Duration: O Up to a month O 1-6 months O 6+ months
Tender skin lesion(s): O Yes O No
Have any lesions been bleeding: O Yes O No
New or changing lesion(s): O Yes O No

Past Medical History

Personal history of the following (select all that apply):
O Eczema O Hayfever O Asthma
Diabetes: O Yes O No
Atypical nevi(Precancerous mole): O Yes O No
Personal history of melanoma: O Yes O No
History of skin cancer: O Yes O No
Artificial Valves/Joints: O Yes O No
Pacemaker/Defibrillator: O Yes O No
AIDS/HIV: O Yes O No
Currently Pregnant: O Yes O No
Bleeding Disorder: O Yes O No
Patients age 65+ that received the Pneumococcal Vaccine (pneumonia): O Yes O No

Family History

First degree relative with melanoma: (Parent or Sibling) O Yes O No
First degree relative with the following (select all that apply):
O Eczema O Hayfever O Asthma

Social History

How often did you have a drink containing alcohol in the past year:
O never O monthly or less O 2 to 4 times a month O 2 to 3 times a week
O 4 or more times a week O 6 or more times a week
If "yes": How many drinks did you have on a typical day when you were drinking in the past year?
O 1 or 2 O 3 or 4 O 5 or 6 O 7 to 9 O 10 or more
If "yes" how often did you have six or more drinks on 1 occasion in the past year?
O never O less than monthly O monthly O weekly O daily or almost daily

Are you a: O current smoker O former smoker O never smoker
If yes how many per day: O 1-2/day O 3-6/day O 7-10/day O 10+/day

Do you:

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

Review of Symptoms

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