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Patient Information Sheet

PLEASE PRINT **Date**: _____

Patient's Name: _____ **Email**: _____

Address: _____ **City**:_____ **State**: _____ **Zip**: _____

Phone: (H)_____ (W) _____ (C) _____

SSN: _____ **DOB**: _____ **Age**: _____ **Sex**: M F **Minor**: Y N

Occupation: _____ **Employer**: _____

Retired: _____ **Full time student**: _____ **Part-time student**:_____

Marital Status: _____ **Name of Spouse/Partner**: _____

***If minor,* Legal Guardian** _____ **Phone(s)**:_____

****

Person Responsible for Payment:

Name: _____ Relationship: _____ Phone: _____

Address: _____ City:_____ State: _____ Zip: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Address: _____ Phone(s): _____

Primary Insurance: _____ Secondary Insurance: _____

Name of Policy Holder: _____ SSN: _____ DOB: _____

Secondary Policy Holder: _____ SSN: _____ DOB: _____

Specialist Co-pay Due at this service: $_____ Surgical Deductible for office procedures: $ _____

Do you have a lab deductible? Y N If so, how much? $_____

Please present insurance cards and photo ID to receptionist so that copies can be made.

RRD History and Intake Form

Name: _____Date: _____
DOB: _____

Past Medical History: (Circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
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
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
Other:

Past Surgical History: (Please list any surgeries below)

Medications:

Allergies:

Reason for Today's visit:

Skin Disease History: (Circle all that apply)

Acne
Actinic keratosis
Asthma
Basal Cell Carcinoma
Blistering Sunburns
Other:
Dry Skin
Eczema
Hay Fever
Melanoma
Poison Ivy
Dysplastic mole
Psoriasis
Squamous Cell Carcinoma
Flaky or itchy scalp

Do you wear Sunscreen? Yes No SPF: _____

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, in which relative?:

Any other family history:

Social History: (Circle all that apply)

Cigarette Smoking:
- Never Smoked
- Former smoker
- Smokes less than daily
- Smokes Daily

Alcohol Use:
- None
- Less than 1 drink per day
- 1-2 drinks per day
- 3 or more drinks per day

Occupation:

If student: What grade or what are you studying?

Hobbies:

Pharmacy:

Reviewed by_____