Patient Name: _____ **DOB:** _____ / _____ / _____

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

Cell: _____ **Email:** _____

Did you receive a new or updated Insurance card this year? □ YES □ NO **Sex:** □ Male □ Female

Name of Insurance _____

Marital Status: □ Single □ Married □ Widowed □ Divorced

Insurance Holder's Name and contact info: _____ **DOB** _____

By Law, medical information is confidential unless written permission is given. Do you want your medical information released to anyone other than yourself? □ YES □ NO **If yes, please print their name and phone #**

_____

Pharmacy (name/town/phone #): _____

Occupation or Previous occupation if retired: _____

Primary Care Physician: _____ **Referring Physician**: _____

Past Medical / Surgical History: Heart Disease, Cancer, Bowel Disease, Etc. _____

_____

Skin Disease History: (please circle all that apply)

- Acne
- Actinic keratosis
- Asthma
- Basal cell skin cancer
- Blistering sunburns
- Dry skin
- Eczema
- Flaking/itchy scalp
- Hay fever/allergies
- Melanoma
- Poison Ivy
- Precancerous moles
- Psoriasis
- Squamous cell skin cancer
- Hepatitis
- HIV

Prescription Medications: (please list Medication and dosage) _____

_____

Drug Allergies: (Please list all known allergies and reactions) _____

_____

Do you wear Sunscreen? □ YES □ NO
If yes, what SPF: _____

Do you have a personal history of Malignant Melanoma? YES □ NO
If yes, location, size and year of diagnosis _____

If you are over the age of 65, have you ever had the pneumonia vaccination? ☐ YES ☐ NO

Do you have a family history of Malignant Melanoma □ YES □ NO
If yes, which relative (s) _____

Did you receive the Flu Vaccination this flu season Or last?
□ YES □ NO If no, □ Refused □ Allergy to Vaccine □ Medical reason

Are you Pregnant or trying to get Pregnant? □ YES □ NO

Social History:
Smoking status: □ Current daily smoker □ Current occasional smoker □ Former smoker □ Never a smoker

If you are a current smoker, Atlantic Shore Dermatology counsels you that smoking causes serious risks to your health and we recommend a smoking cessation plan.

Signature: _____ **Date:** _____