

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)

- | | | |
|--|--|---|
| <ul style="list-style-type: none">• Acne• Actinic keratosis• Asthma• Basal cell skin cancer• Blistering sunburns | <ul style="list-style-type: none">• Dry skin• Eczema• Flaking/itchy scalp• Hay fever/allergies• Melanoma | <ul style="list-style-type: none">• 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 _____

Are you Pregnant or trying to get Pregnant?

YES NO

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

Do you have a healthcare proxy or surrogate in the event you are unable to make your own medical decisions?
 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: _____