

# Adult & Pediatric Dermatology, pc PATIENT REGISTRATION FORM

(Please Print)

Today's Date:	WWW.APDERM.COM
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## PATIENT INFORMATION

Patient's last name:		First:	Middle:	Age:	Date of Birth:		
Race:		Ethnicity:		(Former name):	Preferred Method of Contact:		
<input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Other: <input type="checkbox"/> Declined to Answer		<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Other: <input type="checkbox"/> Declined to Answer			<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Email		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				Sex: <input type="checkbox"/> M <input type="checkbox"/> F			
Email Address:							
Street address:			Cell phone no.:		Home phone no.:		
			(   )		(   )		
P.O. Box:		City:		State:		Zip Code:	
Occupation:		Employer:			Employer phone no.:		
					(   )		
Referred to us by (Please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Our website	<input type="checkbox"/> Other		
Other family members seen here:							

## INSURANCE INFORMATION

Person responsible for bill: (i.e. Policy Holder)		Policy Holders Date of Birth:	Address (if different):		Home phone no.:	
					(   )	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Occupation:		Employer:	Employer address:			Employer phone no.:
						(   )
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						

## PRIMARY CARE PHYSICIAN

Name of Primary Care Physician		Address:		City/ State	Office phone no.:
					(   )

### Please read and sign below

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Adult & Pediatric Dermatology, pc or my insurance company to release any information required to process my claims. I have received and understand the statement of office financial policies and notice of privacy practices.

***Patient/Guardian signature***

***Date***



The person who takes you into the exam room will review this information with you.

Name:

Date of Birth:

### MEDICATIONS

Please list the name of the medication, the dosage (i.e. 5mg, 10mg etc), and the frequency you take it.


### ALLERGIES

Please list all allergies.


### PHARMACY INFORMATION

Any prescription we provide to you today will be sent electronically to your pharmacy of choice. Please list the pharmacy below. If there is more than one pharmacy in your town, please be sure we have the correct street name.

**PHARMACY NAME:**

**PHARMACY TELEPHONE: (if you know it)**

**TOWN OF THE PHARMACY and STREET NAME:**

Do you use a mail away pharmacy? NO

YES If Yes-What is the name of it?

# APDerm® Medical Questionnaire

**Patient Name** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_

**Date:** \_\_\_\_\_  
(please print legibly)

New Patient                       Return Patient

Primary Care Physician  
Name/Address: \_\_\_\_\_

Primary Care Physician Phone#: \_\_\_\_\_

Chief Concern: \_\_\_\_\_ Location: \_\_\_\_\_

Duration of Symptoms: (enter #) \_\_\_\_\_ (check one)  Hours  Days  Weeks  Months  Years

Severity: (check one)  Same  Worse  Better

What things have you tried to help the problem? (i.e. topicals, antibiotics, creams, over the counter product, prescriptions)

\_\_\_\_\_

## **Current Non-Dermatological Problems: (check all that apply)**

Anxiety                       CHF                               Depression     Diabetes     Dizziness     Hepatitis     HIV  
 Irregular Heart Rhythm     Liver Disease     Lymphoma     Other \_\_\_\_\_

## **Surgical History: (check all that apply)**

Basal Cell Carcinoma                       Squamous Cell Carcinoma     Keloids Removed     Melanoma  
 Benign Moles Removed  
 Other Skin Cancer Treatment     Aortic Valve Replacement     Cancer Treatment     Mitral Valve Replacement  
 Pacemaker     Other \_\_\_\_\_

## **Family History: (check all that apply)**

Acne     Basal Cell Carcinoma                       Squamous Cell Carcinoma     Eczema                       Hair Loss  
 Melanoma  
 Psoriasis                       Rosacea

## **Social History: (check all that apply)**

**Occupation:** \_\_\_\_\_ **Smoker?**  Current     Previous     Never    Packs Per Day? \_\_\_\_\_

**Alcohol use:**  Yes     No                                      **Sunscreen Use:**  Yes     No     Sometimes  
SPF? \_\_\_\_\_

**Cosmetic Skin Care: Do you have any cosmetic skin care questions today?**