Coastal Dermatology

& SKIN CARE CENTER

PLEASE FILL OUT ALL PERTINENT SECTIONS AND SIGN WHERE INDICATED. PLEASE PRINT.

Last Name:		First Name:	MI:	Home Phone #:
Street Address:				Work Phone #:
City:	State:	Zip Code:	Sex (M/F):	Cell Phone #:
Date of Birth:				Preferred Contact Number: ☐ Home ☐ Work ☐ Cell
Social Security Number:				Email Address:

PRIMARY INSURANCE INFORMATION

Insurance Carrier:	Your relationship to the insured person: ☐Self ☐Husband ☐Wife ☐Child

Primary Insured Party: Please fill out the following information if the insured party is different from the patient.

Last Name:	First Name:	MI:	Date of Birth:	Insured's Social Security Number:

SECONDARY INSURANCE INFORMATION

Insurance Carrier:	Your relationship to the insured person: ☐Self ☐Husband ☐Wife ☐Child

Secondary Insured Party: Please fill out the following information if the insured party is different from the patient.

Last Name:	First Name:	MI:	Date of Birth:	Insured's Social Security Number:

EMERGENCY CONTACT INFORMATION

Name:	Phone #:	Relation to Patient:

Do you give our office permission to discuss your medical information with the person listed above? ☐ Yes ☐ No

In addition to the emergency contact listed, I give permission for my medical information to be released to the following individuals:

Name:	Phone #:	Relation to Patient:
Name:	Phone #:	Relation to Patient:

PRIMARY CARE PHYSICIAN

Last Name:	First Name:	Phone #:	Address:

PREFERRED PHARMACY

Name:		Phone #:	
Street Address:	City:	State:	Zip Code:

Patient's Name: ____ Date: ____________________

PAST MEDICAL HISTORY

Do you now have, or have you ever had, any of the following conditions? (Check if yes)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ GERD/Acid Reflux
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Thyroid Problem
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE

Other:

____

____

Major Surgeries:

____

____

SKIN DISEASE HISTORY

Do you now have, or have you ever had, any of the following conditions? (Check if yes)

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburn
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ NONE

Other:

____

____

Do you wear sunscreen? ☐ Yes ☐ No If yes, what SPF? __________

Do you tan in a tanning salon or sunbathe? ☐ Yes ☐ No

Do you have a family history of melanoma? ☐ Yes ☐ No

If yes, which relative(s)? ____

Patient's Name: ______________________________ Date: ______________

Current Medications: ☐ NONE

____

____

____

Allergies to Medications: ☐ NONE

____

____

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? ________ ☐ Former smoker

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per day? ________

ADDITIONAL HISTORY

Do you have an allergy to latex? ☐ Yes ☐ No

Do you have an allergy to adhesive? ☐ Yes ☐ No

Do you have an artificial heart valve? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No

Have you had a reaction to local anesthesia? ☐ Yes ☐ No

Have you had a reaction to epinephrine? ☐ Yes ☐ No

Do you take antibiotics before dental or surgical procedures? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No If yes, when is your due date? ______________________________

Are you breastfeeding? ☐ Yes ☐ No