arizona dermatology
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PATIENT INFORMATION

Name:_____ _____ _____ _____
First Name Initial Last Name Nickname

Date of Birth: ____ / ____ / _____ Sex: Male/Female Social Security # _____ - _____ - _____
MM DD YY

Marital Status: Single Married Divorced/Separated Widowed

Address:_____ _____ _____ _____ _____
Street Apt# City State Zip Code

Phone #'s: (_____) _____ - _____ (_____) _____ - _____ (_____) _____ - _____
Home Work Cell

Preferred Contact Line: Home / Work / Cell

E-mail Address: _____

How would you like to be reminded of your appointment? Text Message / Email / Phone message

Would you like to receive e-mails regarding special events and discounted cosmetic services? YES NO

MEDICAL INSURANCE(S)

Primary Insurance Co._____ ID#_____ Relation:_____
Policy Holder name:_____ Date of Birth:___/___/____ Group#_____
Address:_____
Secondary Insurance Co._____ ID#_____ Relation:_____
Policy Holder name:_____ Date of Birth:___/___/____ Group#_____
Address:_____

PRIMARY CARE PHYSICIAN

Full Name: _____ **Phone#: (____) _____ - _____**
Did this Doctor refer you? YES or NO
If "No," how did you find us? Internet/Insurance/Advertising/Event
Friendly Referral: _____ **Other Doctor Referral:**_____

PREFERRED PHARMACY

Name: _____ **Cross streets:**_____
Phone #(____) _____

EMERGENCY CONTACT

Name:_____ **Phone#**_____ **Relationship:**_____

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PAST MEDICAL HISTORY

☐Anxiety
☐Arthritis
☐Atrial Fibrillation
☐Asthma
☐Bone Marrow Transplant
☐BPH
☐Breast Cancer
☐Colon Cancer
☐COPD
☐Coronary Artery Disease
☐Diabetes
☐End Stage Renal Disease
☐GERD
☐Hearing Loss
☐Hepatitis
☐Hypertension
☐HIV/AIDS
☐Hypercholesterolemia
☐Hyperthyroidism
☐Hypothyroidism
☐Leukemia
☐Lung Cancer
☐Lymphoma
☐Prostate Cancer
☐Radiation Treatment
☐Seizures
☐Stroke
☐OTHER:_____

☐

PAST SURGERIES

Have you had surgeries on the following organs?

☐Appendix (Appendectomy)
☐Bladder (Cystectomy)
☐Breast: Mastectomy
  ☐Right Breast
  ☐Left Breast
  ☐Both Breasts
☐Breast: Lumpectomy
  ☐Right Breast
  ☐Left Breast
  ☐Both Breasts
☐Breast: Breast Biopsy
☐Breast: Breast Reduction
☐Breast: Breast Implants
☐Colon (Colectomy): Colon Cancer Resection
☐Colon (Colectomy): Diverticulitis
☐Colon (Colectomy): Inflammatory Bowel Disease
☐Gallbladder (Cholecystectomy)
☐Heart: Coronary Artery Bypass Surgery
☐Heart: PTCA
☐Heart: Mechanical Valve Replacement
☐Heart: Biological Valve Replacement
☐Joint Replacement: Knee
  ☐Right Knee
  ☐Left Knee
  ☐Both knees
☐Joint Replacement: Hip
  ☐Right Hip
  ☐Left Hip
  ☐Both Hips
☐Kidney: Kidney Biopsy
☐Kidney: Nephrectomy
  ☐Kidney: Kidney Stone Removal
☐Kidney: Kidney Transplant
☐Ovaries (Oophorectomy): Endometriosis
☐Ovaries (Oophorectomy): Ovarian Cyst
  ☐Ovaries (Oophorectomy): Ovarian Cancer
  ☐Prostate (Prostatectomy): Prostate Cancer
  ☐Prostate (Prostatectomy): Prostate Biopsy
  ☐Prostate (Prostatectomy): TURP
  ☐Skin: Biopsy
  ☐Skin: Basal Cell Carcinoma
  ☐Skin: Squamous Cell Carcinoma
  ☐Skin: Melanoma
  ☐Spleen (Splenectomy)
  ☐Testicles (Orchiectomy)
  ☐Uterus (Hysterectomy):
    ☐Fibroids
    ☐Uterine Cancer
  ☐Other:_____

☐

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SKIN DISEASE HISTORY

☐Acne
☐Actinic Keratoses (Precancerous lesions)
☐Asthma
☐Basal Cell Skin Cancer
☐Blistering Sunburns
☐Dry Skin
☐Eczema
☐OTHER:_____
_____

☐Flaking or Itchy Scalp
☐Hay Fever/Allergies
☐Melanoma
☐Poison Ivy
☐Precancerous Moles
☐Psoriasis
☐Squamous Cell Skin Cancer

☐NONE

Do you wear sunscreen? YES or NO

If so, what SPF?____

Do you use a tanning salon? YES or NO

FAMILY HISTORY

Do you have a family history of melanoma?
YES or NO

If yes, which relative?

☐Mother
☐Father
☐Sister
☐Brother
☐Daughter
☐Son
☐Uncle
☐OTHER:_____

☐Aunt
☐Niece
☐Nephew
☐Grandmother
☐Grandfather
☐Grandson
☐Granddaughter

☐NONE

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CURRENT MEDICATIONS

Name of Drug	Strength	Frequency	What condition do you take this for?

☐**NONE**

CURRENT DRUG ALLERGIES

Name of Drug	Reaction: Anaphylaxis	Angioedema	Diarrhea	Fatigue	GI Upset	Hives	Liver Toxicity	Rash	Other
	☐	☐	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	☐	☐	

☐**NONE-**No Known Drug Allergies

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SOCIAL HISTORY

Please answer all questions thoroughly in order to give you the best of care

Smoking Status

☐Current everyday smoker
_____Packs a day
☐Current some day smoker
☐Former Smoker
_____Year Quit
☐Never Smoker

Sexual Activity

☐Not sexually active
☐Sexually active with one partner
☐Sexually active with more than one partner
☐Same Sex Partner

Drug Use

☐None
☐IV Drug Use

Alcohol Use

☐None
☐Less than 1 drink per day
☐1-2 Drinks per day
☐3 or more drinks

Home Environment

☐Feels Safe At Home
☐Feels Unsafe At Home

Caffeine Use

☐Several Times a Day
☐Once a Day
☐Never

Exercise

☐Daily
☐Few times a week
☐Never

OCCUPATION AND WORKPLACE

Occupation:_____
Workplace:_____

Approximately, how many hours does your job expose you to the sun each week? _____

EMERGENCY CONTACT FOR PATHOLOGY RESULTS

Please list a contact for pathology results if you cannot be reached

Name: _____ **Phone# (____)**_____
Relationship:_____

Demographics

Language at Home:_____
Race:_____
Ethnic Group: ☐Hispanic/Latino
☐Non Hispanic/Latino
Next of Kin:_____

Reason for Visit

_____
_____
_____
_____

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REVIEW OF SYSTEMS

☐Fever or Chills
☐Night Sweats
☐Unintentional Weight Loss
☐Cough
☐Abdominal Pain
☐Joint Aches
☐Muscle Weakness
☐Weakened Immune System
☐Hay Fever / Allergies

☐Problems with Scarring (Hypertrophic or Keloid)
☐Chest Pain
☐Shortness of Breath
☐Headaches
☐Sore Throat
☐Anxiety
☐Depression
☐Vision Problems

☐NONE

-ALERTS-

CHECK ALL THAT APPLY

☐Latex Allergy
☐Lidocaine Allergy
☐Epinephrine Sensitivity
☐Pacemaker/Defibrillator
☐Blood Thinners
☐Adhesive Allergy
☐Topical Antibiotic Allergy
☐Pregnant/Planning Pregnancy

☐Bleeding Problems
☐History of Melanoma:
Year_____
☐History of Basal Cell Carcinoma
☐History of Squamous Cell Carcinoma
☐History of Dysplastic Nevus
☐Hepatitis B/C
☐HIV/AIDS

☐NONE

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INSURANCE POLICY

WE APPRECIATE THE OPPROTUNITY OF SERVING YOU.
WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE.

INSURANCE POLICY:

As a courtesy to you, we will submit all itemized statements to your insurance carrier, if you have provided information. You are responsible for all deductibles, co-pay, co-insurance, etc, that are not covered by your insurance. Please understand we cannot, as a third party, become involved in prolonged negotiations, this is your responsibility.

I authorize the release of any medical information necessary to process any and all claims. I permit a copy of the authorization to be used in place of the original. Either my insurance company or I may revoke the authorization at any time in writing.

Signed:_____ **Date:**_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the doctor/provider to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and in times when provider deems it necessary.

Signed:_____ **Date:**_____

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Cancellation/ No Show Policy

Arizona Skin and Laser

Arizona Skin and Laser policy requires, minimum, 24-hour notice to cancel an appointment. If an accumulation of 3 cancellations without 24-hour notice and/or no shows occurs, we will discharge that patient from the practice.

Please sign to acknowledge your understanding and acceptance to comply with our office policy.

_____ _____

Patient Signature Date

_____

Print Patient Name

If you are a representative for the patient with their care please sign below

_____ _____

Representative Signature Date

_____

Print name and Title

For Office Use Only:

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PATIENT COMMUNICATION SHEET

PATIENT NAME:_____

Date:_____

The following instructions pertain to the above named Patient:
(Please make appropriate selection)

_____ OK to call home and leave messages

_____ Do NOT leave messages

_____Do NOT call home phone
***Call only this number:_____

_____ Do NOT speak to family members

_____ Permission to speak with ONLY family members listed below:

1._____ Relation:_____
2._____ Relation:_____
3._____ Relation:_____
4._____ Relation:_____

Signed:_____ **Date:**_____

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ACKNOWLEDGEMENT OR RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received a copy of Arizona Skin & Laser Inst. Ltd. "Notice of Privacy Practices." This notice describes how Arizona Skin & Laser Therapy Inst. Ltd. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare and the rights I may have regarding my protected health information.

_____ _____

Patient Signature Date

_____

Print Patient Name

***If you are a representative for the patient with their care please sign below

_____ _____

Representative Signature Date

_____

Print Name and Title