Patient Information Record

(Please print legibly and please answer **ALL QUESTIONS)**

Thank you for choosing Davis Dermatology.
We are glad you are here and look forward to a long lasting relationship.

Patirnt Name _____ Date of Birth _____

Social Security # (required _____ Email Address _____

Would you like to receive periodic clinical /medical newsletters and special offers from Dr. Davis: ☐ Yes ☐ No

☐ Home Phone _____ ☐ Cell Phone _____ Cell Carrier _____

Please place a check next to the phone number you would like to be contacted on.

Permanent Address _____ City _____ State _____ Zip Code _____

Temorary Address _____ City _____ State _____ Zip Code _____

Occupation _____ Work Phone _____ Check if Retired ☐

<u>If patient is under 18 yrs. Of age please complete the following section</u>

Guardian Name _____ Relationship _____ Phone Number _____

Address _____ City _____ State _____ Zip Code _____
(If different than above)

ALL PATIENTS please complete below

Primary Insurance Carrier _____ ID # _____ Group # _____

Policy Holder's Name _____ Relationship _____

Secondary Insurance Carrier _____ ID # _____ Group # _____

How did you hear about Davis Dermatology?

☐ Dr. Referral ☐ Pt. Referral ☐ Newspaper ☐ Internet ☐ Other _____

If referred by a physician or another patient please list their name _____

PLEASE COMPLETE OTHER SIDE

Patient Name_____ Date _____

Previous Health History

Have you ever been diagnosed with or treated for the following problems?

- ☐ Yes ☐ No Genetic disease
- ☐ Yes ☐ No Emotional/Mental Illness
- ☐ Yes ☐ No Melanoma
- ☐ Yes ☐ No Collagen vascular disease
- ☐ Yes ☐ No Arthritis
- ☐ Yes ☐ No Neurologic disease
- ☐ Yes ☐ No Seizures
- ☐ Yes ☐ No Stroke
- ☐ Yes ☐ No Vascular (vein) disease/blood clots
- ☐ Yes ☐ No Heart disease
- ☐ Yes ☐ No High blood pressure
- ☐ Yes ☐ No Pacemaker/defibrillator
- ☐ Yes ☐ No Diabetes
- ☐ Yes ☐ No Thyroid disease
- ☐ Yes ☐ No Other gland (endocrine) disease
- ☐ Yes ☐ No Stomach or intestinal ulcer/stomach disease

CONTINUED ON OTHER SIDE

☐ Yes ☐ No Colon disease

☐ Yes ☐ No Hepatitis or other liver disease

☐ Yes ☐ No Lung disease

☐ Yes ☐ No Asthma or repiratory allergies

☐ Yes ☐ No Kidney disease

☐ Yes ☐ No Cancer (skin)

☐ Yes ☐ No Cancer (other) body site _____

☐ Yes ☐ No Glaucoma

☐ Yes ☐ No Hernia

☐ Yes ☐ No History of blood transfusion/positive for HIV

☐ Yes ☐ No Other Medical Problems _____

_____

_____

☐ Yes ☐ No Are you presently pregnant or planning a pregnancy?

☐ Yes ☐ No Are you allergic to aany medications? If yes please list _____

_____

_____

☐ Yes ☐ No Have you ever had surgery? Please list _____

_____

☐ Yes ☐ No Have you had any significant mental illness? Please list _____

_____

☐ Yes ☐ No Have you ever been hospitalized? Please List _____

_____

_____

☐ Yes ☐ No Are you taking any medication? Please list _____

_____

_____

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