MRN:

DESERT SKY DERMATOLOGY, PLLC
PATIENT REGISTRATION

Please complete all fields—Thank you!

Patient Name_____ **Date of Birth**_____

SSN_____ **Phone (H)** _____ **Phone (C)**_____

Address_____ **City**_____ **Zip**_____

Email_____ **Gender** _____Male _____Female

Marital status ___Single ___Married ___Divorced ___Legally Separated

Occupation_____ **Employer**_____

Referring provider _____ **Location**_____ **Phone**_____

Primary care provider _____ **Location** _____ **Phone** _____

Preferred pharmacy_____ **Address (or cross streets)** _____

Reason for visit:_____

Ethnicity: ___Hispanic ___Non-Hispanic

Race: ___American Indian/Alaska Native ___Asian/Asian American ___Black/African American
___Native Hawaiian/Other Pacific Islander ___ White ___Other

Primary Insurance _____Subscriber (Insured)_____
Subscriber's date of birth _____Patient's relationship to subscriber (circle) Self/ Spouse/ Child /Other
Group #_____ID#_____
Medical claims address _____
Secondary Insurance _____Subscriber (Insured) _____
Subscriber's date of birth _____ Patient's relationship to subscriber (circle) Self/ Spouse/ Child/Other
Group #_____ID#_____
Medical claims address _____

General Medical History

Select any of the following medical conditions that you **currently** have:

- ☐ **NONE**
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Bone Marrow Transplantation
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes ____Type 1 ____Type 2
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Other:_____

(CONTINUED ON NEXT SIDE)

Past Surgeries: _____

Pacemaker or defibrillator? ____YES ____NO

Artificial Joints? ____YES ____NO If yes, which joint? _____ When? _____

Skin-Related Medical History

Select any of the following skin conditions that you **currently or previously** have experienced:

- ☐ **NONE**
- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Carcinoma
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever / Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma
- ☐ Other:_____

Do you use sunscreen? Yes / No If yes, what SPF? _____ Do you use it daily? Yes / No

Do you tan in a tanning salon? Yes / No

Do you have a **family** history of skin cancer? Yes / No

If yes, who? _____

Malignant Melanoma? Yes / No

Do you have a **personal** history of skin cancer? Yes / No

If yes, where? _____ When?_____

Malignant Melanoma? Yes/No If yes, When?_____

Please list all current medications or attach a current medication list

Name:	Dosage:	Purpose:

Allergies to medications? (Please List) _____

Social History

Are you pregnant? Yes / No Are you breastfeeding? Yes / No

Do you smoke? Yes / No Chewing tobacco? Yes / No Have you ever used tobacco products? Yes / No

Have you had a Pneumonia vaccine? Yes / No

SIGNATURE: _____ **Date:** _____

OR -- SIGNATURE OF PARENT OR LEGAL GUARDIAN: _____

RELATIONSHIP: _____