

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 _____

Past General Medical History

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

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

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:** _____

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

SIGNATURE: _____

Date: _____

OR -- SIGNATURE OF PARENT OR LEGAL GUARDIAN: _____

RELATIONSHIP: _____