First Name: _____Middle: _____Last: _____

Marital status: Married/Single/Divorced/Other SSN: ____-_____-_____ Gender: M/F Birthdate: ___/___/__

Home Address: _____City_____State _____ Zip_____

Home Phone: _____CELL _____ Work _____

Email Address: _____@_____ **May we contact you by email? Yes No**

Best contact: ☐ Home ☐ Work ☐ Cell May we leave a message? ☐ Voicemail ☐ Person

Individuals with whom we may discuss your medical information: _____

Emergency contact Name & Phone Number: _____

FINANCIAL INFORMATION

Person Responsible for payment: _____ Relationship: _____

Address: _____City_____State_____Zip _____

Phone: **Home** _____ **Work** _____ **Cell** _____

SSN: _____-_____-_____ Date of Birth: _____ Occupation: _____

INSURANCE INFORMATION

Primary Insurance: _____Relationship to Patient _____

Subscribers Name for Primary: _____ Date of Birth: _____

Secondary Insurance: _____Relationship to Patient _____

WHO MAY WE THANK FOR THE REFFERAL?

CONSENT FOR TREATMENT: By signing this form, you consent to our disclosure of protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy provides more detailed information about how we may use and disclose this protected health information. You have legal right to review our Notice of Privacy Practices before you sign this consent and we encourage you to read it in full. Your signature indicates you understand and acknowledged the notice of privacy Practices. The Notice of Privacy Practices is subject to change. You may obtain a copy of the revised notice by contacting Pasadena Premier Dermatology at (626)449-4208.

Patient Signature: _____

PATIENT INFORMATION

Last name: _____First:_____Middle:_____

Primary Language: __English __Arabic __French__German__Mandarin__Spanish__Russian__Other

Race: __American Indian __Asian __African American or Black __White __Unknown __Other

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Primary Pharmacy: _____Address: _____Phone:_____

CRITICAL/PAST MEDICAL HISTORY

MRSA □ Yes □ No HSV/cold sore □ yes □ No

MELANOMA HISTORY

Do you have a history of melanoma? □ yes □ No

Do you have a history of other skin cancer(s) □ yes □ No

CURRENT MEDICATIONS

Medication: _____Dose: _____ Medication:_____Dose: _____

Medication: _____Dose: _____ Medication:_____Dose: _____

MEDICATION ALLERGIES

Do you have any medication allergies? □ yes □ No

List Allergies: _____

FAMILY HISTORY OF SKIN CANCER

Do you have a family history of melanoma? □ yes □ No Who:

Do you have a family history of other skin cancer(s) □ yes □ No Who:

SOCIAL HISTORY

Do you use tobacco? □ Current □ Former □ Never

Alcohol consumption? □ Never □ Daily □ Weekly □ Monthly

PERSONAL INFORMATION