

WELCOME TO OUR OFFICE. PLEASE TAKE A MOMENT TO COMPLETE THIS FORM IN ITS ENTIRETY.

LAST NAME	FIRST	INT	SEX M F	D.O.B.	
STREET ADDRESS			CITY/ STATE/ ZIP	HOME PHONE	CELL PHONE
PATIENT'S OR PARENT'S EMPLOYER			OCCUPATION (INDICATE IF STUDENT)	BUSINESS PHONE	
DO YOU HAVE A PRIMARY CARE PHYSICIAN? Y N					
IF YES, WHO? SPOUSE'S EMPLOYER			OCCUPATION)	BUSINESS PHONE	
EMAIL ADDRESS:			REFERRED BY: HOW DID YOU HEAR ABOUT OUR OFFICE?		

PERSONAL INFORMATION

INSURANCE INFORMATION

INSURED/PARTY RESPONSIBLE	ADDRESS (IF DIFFERENT FROM ABOVE)	Relationship to patient	Insured's DOB
			SS# (IF NEEDED FOR BILLING)
PRIMARY INSURANCE COMPANY	GROUP NUMBER	MEMBER ID NUMBER	
SECONDARY INSURANCE COMPANY	GROUP NUMBER		

EMERGENCY CONTACTS

PLEASE LIST BELOW SOMEONE WE MAY CONTACT IN CASE OF AN EMERGENCY

NAME	PHONE NUMBER	RELATIONSHIP
NAME	PHONE NUMBER	RELATIONSHIP

CURRENT PROBLEM

BRIEFLY STATE YOUR PROBLEM. DO YOU HAVE ANY SYMPTOMS LIKE BURNING OR ITCHING ASSOCIATED WITH IT?		
HOW LONG HAVE YOU HAD THIS?	HAVE YOU HAD IT BEFORE? IF SO, WHEN	HAVE YOU BEEN TREATED FOR THIS BEFORE?

History and Intake Form

Past Medical History: (please circle all that apply with date of diagnosis)

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Artificial Joints	End Stage Renal Disease	Lymphoma
Asthma	GERD	Other Cancer _____
Atrial Fibrillation	Hearing Loss	Pacemaker
BPH	Hepatitis	Prostate Cancer
Bone Marrow Transplantation	Hypertension	Radiation Treatment
Breast Cancer	HIV/AIDS	Seizures
Colon Cancer	Hypercholesterolemia	Stroke
COPD	Hyperthyroidism	Valve Replacement
Coronary Artery Disease	Hypothyroidism	
Other _____		

Past Surgical History: (please circle all that apply with date of surgery)

Appendix Removed	Kidney Biopsy
Bladder Removed	Kidney Removed (Right, Left)
Mastectomy (Right, Left, Bilateral)	Kidney Stone Removal
Lumpectomy (Right, Left Bilateral)	Kidney Transplant
Breast Biopsy (Right, Left, Bilateral)	Ovaries Removed: Endometriosis
Breast Reduction	Ovaries Removed: Cyst
Breast Implants	Ovaries Removed: Ovarian Cancer
Colectomy: Colon Cancer Resection	Prostate Removed: Prostate Cancer
Colectomy: Diverticulitis	Prostate Biopsy
Colectomy: IBD	TURP
Gallbladder Removed	Skin Biopsy
Coronary Artery Bypass	Basal Cell Cancer Surgery
PTCA	Squamous Cell Carcinoma Surgery
Mechanical Valve Replacement	Melanoma Surgery
Biological Valve Replacement	Spleen Removed
Heart Transplant	Testicles Removed (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left Bilateral)	Hysterectomy: Fibroids
Joint Replacement within last 2 years	Hysterectomy: Uterine Cancer
Other _____	

Family History: (please circle all that apply)

Arthritis	Diabetes	Lung Cancer
Asthma	End Stage Renal Disease	Lymphoma
Atrial Fibrillation	GERD	Other Cancer _____
BPH	Hepatitis	Prostate Cancer
Breast Cancer	Hypertension	Seizures
Colon Cancer	Hypercholesterolemia	Stroke
COPD Hypertension	Hyperthyroidism	
Coronary Artery Disease	Hypothyroidism	
Other _____		

Are you currently pregnant? _____

If yes, how long? _____

Number of Pregnancies _____ Miscarriages _____

Are you post menopausal? _____

If yes, how long? _____

Skin Disease History: (please circle all that apply)

Acne	Eczema	Psoriasis
Actinic Keratoses	Flaking or Itchy Scalp	Squamous Cell Skin
Asthma	Hay Fever/Allergies	Cancer
Basal Cell Skin Cancer	Melanoma	None
Blistering Sunburns	Poison Ivy	
Dry Skin	Precancerous Moles	
Other _____		

Do you wear Sunscreen daily? Yes No
If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____

Do you have a family history of SCC/BCC? Yes No
If yes, which relative(s)? _____

Medications: (Please enter all current medications)

Supplements: (Please enter all current supplements)

Allergies: (Please enter all allergies)

Social History: (Please circle all that apply)

Currently Smokes – daily	Alcohol Use
Currently Smokes – not daily	Illicit Drug Use
Has smoked in the past	None
Has never smoked	
Other _____	

Patient Signature _____ Date _____

MD _____ Date _____

PLEASE READ CAREFULLY

I UNDERSTAND THAT DR. ROSE DERMATOLOGY PARTICIPATES WITH CERTAIN INSURANCE CARRIERS. UNLESS A CONTRACTUAL ARRANGEMENT EXISTS BETWEEN DR. ROSE AND MY INSURANCE COMPANY, I AGREE TO PAY THE FEES IN FULL, EVEN THOUGH THE AMOUNT MAY BE GREATER THAN WHAT I AM ENTITLED TO RECEIVE FROM MY INSURANCE CARRIER. ANY CO/PAYS, DEDUCTIBLES, OR AMOUNTS DEEMED PAYABLE BY MY INSURANCE CARRIER SHALL BE MY RESPONSIBILITY. BALANCES REFLECTED ON THE OFFICE BILL, WHICH IS NOT EXPECTED TO BE REIMBURSED BY INSURANCE, SHALL BE PAYABLE BY ME. PROCEDURES DEEMED "COSMETIC", BY ANY INSURANCE CARRIER, WILL BE MY RESPONSIBILITY. THERE IS A \$25.00 FEE FOR ALL UNPAYABLE CHECKS.

SIGNATURE _____

DATE _____

AN IMPORTANT MESSAGE REGARDING MOLES AND MELANOMAS

THE INCIDENCE OF MALIGNANT MELANOMA IS ON THE RISE. IN EFFORT TO IDENTIFY AND TREAT THIS CONDITION, IT IS RECOMMENDED THAT A TOTAL SKIN OR DERMATOLOGICAL BODY EXAM BE PERFORMED. BY VISUAL EXAMINATION OF MOLES, ON THE SKIN, WE CAN EVALUATE THE STATUS OF THOSE LESIONS AND DETERMINE IF TREATMENT IS NEEDED AT THIS TIME,

NO ONE KNOWS WHAT THE STIMULUS IS FOR SUCH LESIONS TO UNDERGO MALIGNANT CHANGES. VARIOUS FACTORS SUCH AS SPORADIC SUN BURNS, PROLONGED SUN EXPOSURE, TRAUMA, FRICTION, HORMONAL INFLUENCES AND HEREDITY HAVE BEEN INVOLVED IN THE DEVELOPMENT OF MALIGNANT CHANGES (CALLED MELANOMA). BECAUSE OF THE RAPID EVOLUTION OF MELANOMAS, IT IS OF THE UTMOST IMPORTANCE THAT QUICK AND EARLY DIAGNOSIS BE MADE. TREATMENT MUST BE DONE TO REMOVE SUCH A LESION ENTIRELY AND THOROUGHLY. CURRENTLY, PROGRESS IS BEING MADE IN THE CHEMICAL TREATMENT OF THOSE PATIENTS WHOSE DISEASE HAS SPREAD TO OTHER PARTS OF THE BODY; HOWEVER THE BEST HOPE IS FOR EARLY DIAGNOSIS AND REMOVAL.

DERMATOLOGISTS ARE TRAINED TO CLINICALLY RECOGNIZE THE TYPES OF CHANGES THAT TAKE PLACE IN MELANOMA AND ARE KNOWLEDGEABLE OF THE MICROSCOPIC ASPECTS OF THIS CONDITION. APPROACHES IN TREATMENT OF SUCH LESIONS ARE IN THE FOREFRONT OF GOOD DERMATOLOGICAL PRACTICE. ANY CHANGE WHATSOEVER IN A MOLE SHOULD BE CAREFULLY EVALUATED BY A DERMATOLOGIST.

ACCORDINGLY, THIS DERMATOLOGICAL PRACTICE IS OFFERING TO PATIENTS TOTAL BODY DERMATOLOGICAL EXAMINATION WITH APPROPRIATE RECOMMENDATIONS. THIS WILL INCLUDE A FULL HEAD-TO-TOE SURVEY OF THE ENTIRE SKIN. ANY SUSPICIOUS LESIONS CAN AND WILL BE REMOVED. THAT TISSUE WILL BE SENT FOR HISTOLOGICAL EXAMINATION BY A BOARD CERTIFIED DERMOPATHOLOGIST WHO WILL BILL YOU DIRECTLY. THE USUAL SURGICAL FEES WILL BE APPLIED FOR SUCH SERVICES IN THIS OFFICE.

ON THIS VISIT TO OUR OFFICE TODAY WE EXTEND TO YOU THE OPPORTUNITY TO HAVE THE ABOVE NOTED DERMATOLOGICAL EXAMINATION PERFORMED ON YOU. BECAUSE OF THE IMPORTANCE OF THIS VERY SERIOUS CONDITION, WE RECOMMEND THAT IT BE DONE.

PLEASE SIGN AND DATE THIS FORM ACKNOWLEDGING WHETHER OR NOT YOU WISH TO HAVE THIS PROCEDURE PERFORMED.

_____ YES, I WISH TO HAVE THE EXAMINATION PERFORMED.

_____ NO, I DO NOT WISH TO HAVE THE EXAMINATION PERFORMED.

SIGNATURE

DATE