

CAROLINA DERMATOLOGY

OF GREENVILLE

Patient Information:

Date: _____

First, MI, Last Name: _____ Date of Birth: _____

SSN: _____ Gender at birth: ☐ Male ☐ Female Identify as: ☐ Male ☐ Female

Address: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Race: _____ Ethnicity: _____ Need Interpreter: ☐ Yes ☐ No Language: _____**NOTE: If patient is a minor, provide Parent or Guardian Name, DOB, and Relationship below:**

_____/_____/_____

Address (if different from above): _____

Primary Care Provider: _____ Referring Provider: _____

Preferred Pharmacy and Location: _____

Insurance Information: (Please bring insurance card(s) to appointment.)

Primary Insurance: _____ ID No: _____

Secondary Insurance: _____ ID No: _____

Medical History:

Briefly, what brings you in today: _____

Personal History of Skin Cancer: ☐ Yes ☐ No If Yes, Type: ☐ Basal Cell Carcinoma ☐ Squamous Cell Carcinoma
☐ Melanoma ☐ Other: _____Family History of Skin Cancer: ☐ Yes ☐ No Family Member(s): _____History of skin disease: ☐ Yes ☐ No If yes, what type? _____

List any other diseases or conditions you have: _____

Pregnant: ☐ Yes ☐ No If yes, how many weeks: _____ Breastfeeding: ☐ Yes ☐ NoPacemaker/Defibrillator: ☐ Yes ☐ No Artificial Heart Valve: ☐ Yes ☐ No Joint Replacement: ☐ Yes ☐ NoHIV: ☐ Yes ☐ No Hepatitis B or C: ☐ Yes ☐ No Diabetes: ☐ Yes ☐ No Blood Thinner: ☐ Yes ☐ No _____Personal History of Cancer: ☐ Yes ☐ No If yes, what type? _____

List Current Medications (dose not necessary):

Medication Allergies: ☐ Yes ☐ No If yes, which one(s)? _____