

# CAROLINA DERMATOLOGY

OF GREENVILLE

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Phone: 864-233-6338 Fax: 864-235-1982 [www.carolinaderm.com](http://www.carolinaderm.com)

**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  No

Pacemaker/Defibrillator:  Yes  No Artificial Heart Valve:  Yes  No Joint Replacement:  Yes  No

HIV:  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)? \_\_\_\_\_