ENCHANTRESS DERMATOLOGY

PATIENT INFORMATION FORM

Date _____

First name _____ Last name _____

Date of Birth ____/____/_____ □ Male □ Female

If underage, Parent or Legal Guardian (name and DOB)

_____

Race _____ Ethnicity _____ Language _____

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Phone number _____ Email Address _____

Do you authorize Enchantress Dermatology® to send text messages to the cell phone number registered through your telecommunications company? Yes □ No □

Primary Care Physician Name and Phone Number _____

How did you hear of Enchantress Dermatology®? _____

INSURANCE INFORMATION

Primary Insurance _____

Policy holder name _____

Policy number _____

Group number _____

Policy type □ HMO □ PPO □ Other: _____

Patient Relationship to Policy Holder

□ Self □ Spouse □ Daughter □ Son

Secondary Insurance _____

Policy holder name _____

Policy number _____

Group number _____

Policy type □ HMO □ PPO □ Other: _____

Patient Relationship to Policy Holder

□ Self □ Spouse □ Daughter □ Son

If you are not the policy holder, please provide Policy Holder DOB: _____

In case of Emergency, who should be notified? (Name, Relationship, and phone number)

_____

PRIVACY POLICIES

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Your signature below signifies that you have received our Notice of Privacy Practices for Protected Health Information.

_____

Signature of patient or legal guardian Date

_____

Printed name of patient

May we leave confidential messages?

Yes / No If yes, please indicate the phone number and sign below.

_____

Signature Phone number

It is the practice of this office not to release your medical information to anyone without your written authorization. If you would like our office to discuss your confidential medical information with someone other than you (such as your primary care physician, spouse, or family member) please list the person(s) and their relationship to you.

_____ _____

Printed Name of Authorized Person Relationship

_____ _____

Printed Name of Authorized Person Relationship

_____ _____

Printed Name of Authorized Person Relationship

PHARMACY OF CHOICE

Name: _____ Phone Number: _____

Pharmacy Address: _____

Past Medical History (Please select all that apply)

□ Anxiety disorder
□ Arthritis
□ Asthma
□ Atrial Fibrillation
□ Benign prostatic hyperplasia
□ Cerebrovascular accident
□ COPD
□ Coronary arteriosclerosis
□ Depressive disorder
□ Diabetes mellitus
□ Disease caused by COVID-19
□ Elevate blood pressure
□ End Stage Renal Disease
□ Epilepsy
□ GERD
□ Hearing Loss
□ HIV / AIDS
□ High Cholesterol
□ Hyperthyroidism
□ Hypothyroidism
□ Inflammatory disease of liver
□ Leukemia
□ Lymphoma
□ Malignant tumor of lung
□ Malignant tumor of breast
□ Malignant tumor of colon
□ Malignant tumor of prostate
□ Radiation Treatment
□ Bone Marrow Transplant

□ **NONE**

Other: _____

Past Surgical History (Please select all that apply)

□ Knee replacement
□ Biopsy of breast
□ Biopsy if prostate
□ Heart: Coronary artery bypass graft
□ Kidney: Transplant
□ Skin: Basal cell carcinoma
□ Skin: Melanoma
□ Skin: Squamous cell carcinoma
□ History of Colostomy
□ History of Tubal ligation
□ Appendectomy (appendix)
□ Cholecystectomy (gallbladder)
□ Colectomy (colon)
□ Liver excision
□ Heart: coronary angioplasty
□ Heart valve replacement
□ Cystectomy (bladder)
□ Hysterectomy (uterus)
□ Kidney: Biopsy
□ Rectum resection
□ Breast tumor resection (□ Left □ Right)
□ Mastectomy (□ Left □ Right)
□ Heart: Mechanical Valve Replacement
□ Ovaries Removed: Endometriosis
□ Ovaries Removed: Ovarian Cancer
□ Pancreas: Pancreatectomy
□ Kidney: Stone Removal
□ Prostatectomy (prostate)
□ Splenectomy (spleen)
□ Skin: Biopsy
□ Kidney: Nephrectomy
□ Hip Replacement (□ Left □ Right)
□ Heart: Transplant
□ Liver: Transplant
□ Cosmetic surgery

□ **NONE**

Other: _____

_____

Skin Disease History (Please select all that apply)

□ Acne
□ Actinic keratosis
□ Dry skin
□ Basal Cell Skin Cancer
□ Contact dermatitis due to poison ivy
□ Dysplastic nevus
□ Eczema
□ History of asthma
□ History of hay fever
□ Melanoma
□ Itchy Scalp
□ Psoriasis
□ Squamous Skin Cancer
□ Sunburn of second degree
□ **NONE**

Other: _____

Do you wear sunscreen every day? □ Yes □ No If yes, what SPF? _____

Do you tan in a tanning salon? □ Yes □ No

Do you have family history of Skin cancer? □ Yes □ No

Do you have family history of Melanoma? □ Yes □ No

If yes, which relative(s)? _____

MEDICATIONS (Please list all current medications & dosages)

_____

_____

_____

ALLERGIES (Please list all allergies)

□ Acetaminophen
□ Aspirin
□ Codeine
□ Epinephrine
□ Erythromycin
□ Ibuprofen
□ Iodine
□ Latex
□ Lidocaine
□ Metal
□ Penicillin
□ Sulfas
□ Sulfur
□ Tetracycline
□ **NKDA (None)**

□ Other: _____

SOCIAL HISTORY

Cigarette Smoking:
□ Never Smoked
□ Currently every day smoker
□ Currently some day smoker
□ Has smoked in the past

Alcohol use:
□ None
□ Less than 1 drink per day
□ 1-2 drinks per day
□ 3 or more drinks per day

Occupation: _____

FAMILY HISTORY
(Significant diseases & illness. Only first-degree biological relatives: mother, father, brother, sister & children)

CONDITION	RELATIVE

REVIEW OF SYSTEMS: Are you currently experiencing any of the following?

SYMPTOM	YES	NO
Problems with bleeding		
Problems with healing		
Problems with scarring (keloids)		
Rash		

ALERTS (please check all that apply)

□ Allergy to adhesive
□ Allergy to iodine
□ Allergy to lidocaine
□ Allergy to topical antibiotic
□ Artificial heart valve
□ Artificial joints within past 2 years
□ Blood thinners
□ Defibrillator
□ Hepatitis B/C
□ HIV / AIDS
□ Lactating / Breast feeding
□ Latex allergy
□ MRSA
□ Medication allergy
□ Pacemaker
□ Premedication prior to procedures
□ Pregnant or Planning pregnancy

IMMUNIZATIONS
Have you had the following immunizations?

Vaccine	**Date of Vaccination (can be approximate if unsure)**
Influenza (Flu)	
Pneumonia	
Varicella (Shingles)	
COVID-19	