Signatures ☐ Opt Out ☐ RxEligibility ☐ HMO ☐

Goldin Skin Dermatology

PATIENT INFORMATION SHEET Today's Date: _____

Name: Last_____First_____MI_____

Address: _____

City:_____ State: _____ Zip:_____

Phone: Home: ( )_____ Work: ( )_____

Cell Phone: _____

E-Mail_____

Sex: M F Marital Status: S M D W

Age: _____ Date of Birth: _____ SSN: _____

DO YOU HAVE AN HMO PLAN? ☐Yes ☐ No

You must bring a referral with you for each visit.

HOW WOULD YOU LIKE US TO CONTACT YOU?

We prefer to email you via our secure patient portal. A login is required.
Circle your response(s): Voice Text Email ☐opt out of newsletter

WE ARE REQUIRED TO ASK THE FOLLOWING BY THE GOVERNMENT:

Ethnicity: *Circle your response:* Not Hispanic/Latino Hispanic/Latino

Race: *Circle your response:* White Black/African American Hispanic Asian Other

Preferred Language: *Circle your response:* English Russian Korean Other: _____

MEDICAL INFORMATION

PHYSICIANS:
PRIMARY: _____ Address: _____
OTHER: _____Address: _____
OTHER: _____Address: _____

PHARMACY: Name: _____ City: _____
Street/Intersection:_____

IN CASE OF EMERGENCY NOTIFY:

Name:_____Address:_____
_____Relationship:_____Phone:_____

Turn Page

SOCIAL HISTORY:

Occupation: _____

Who lives with you at home?_____

Do you go to tanning salons? ☐Yes ☐ No (If yes, we recommend that you stop.)

Do you smoke? ☐Yes ☐No (If yes, we recommend that you stop.)

SKIN CANCERS: Basal Cell Carcinoma Squamous Cell Carcinoma Melanoma

Location:_____ Date:_____

_____ Date: _____

MEDICAL CONDITIONS: *Please list:*

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

MAJOR SURGERIES: *Please list:*

_____ _____ _____

_____ _____ _____

CURRENT MEDICATIONS: *(Include Vitamins, Herbs, and Supplements) Please list:*

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

( ) I do not take any medications.

FEMALE PATIENTS: Are you pregnant? ☐Yes ☐ No Are you nursing? ☐ Yes ☐ No

FAMILY HISTORY:

Melanoma-Who: _____ Are they alive? ☐Yes ☐ No

ALLERGIES TO MEDICATIONS: *Please list:*

_____ _____ _____

_____ _____ _____

( ) I have no known allergies to medications

WHAT IS/ARE THE MAIN REASON(S) YOU CAME TODAY?

1._____

2._____

3._____