
# New Patient Paperwork

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**Patient Information**
**PLEASE PROVIDE FULL LEGAL NAME FOR INSURANCE AND PRESCRIPTION PURPOSES**

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Patient Name:_____ Date Of Birth_____ Age:_____

Birth Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Preferred Language: _____ Race:_____
Email Address:_____
Home Phone:_____ Mobile Phone:_____ Work Phone:_____

Is it OK to leave a detailed message: ☐ Yes ☐ No

**Emergency Contact**
Name_____ Phone number _____ Relationship _____

**Billing Address**
Street:_____
City:_____
State:_____ Zip Code:_____
Seasonal Address (if applicable):
Street:_____
City:_____
State:_____ Zip Code:_____

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**Patient Medical Insurance**

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Primary Insurance:_____
ID Number / Policy Number:_____ Group Number:_____
Policy Holder:_____ Relationship To Patient:_____
Policy Holder D.O.B.:_____
Secondary Insurance:_____
ID Number / Policy Number:_____ Group Number:_____
Policy Holder:_____ Relationship To Patient:_____
Policy Holder D.O.B.:_____

## Past Medical History

**Past Medical Conditions**

- [ ] None
- [ ] Anxiety disorder
- [ ] Arthritis
- [ ] Asthma
- [ ] Atrial Fibrillation
- [ ] Benign Prostatic Hyperplasia
- [ ] Cerebrovascular Accident
- [ ] Chronic Obstructive Lung Disease
- [ ] Coronary Arteriosclerosis
- [ ] Depressive Disorder
- [ ] Diabetes Mellitus
- [ ] Disease caused by COVID
- [ ] Elevated Blood Pressure
- [ ] End-Stage Renal Disease
- [ ] Epilepsy
- [ ] Gastroesophageal Reflux Disease (GERD)
- [ ] History of Hypertension (high blood pressure)
- [ ] Hearing Loss
- [ ] Human Immunodeficiency Virus Infection
- [ ] Hypercholesterolemia (high cholesterol)
- [ ] Hyperthyroidism
- [ ] Hypothyroidism
- [ ] Inflammatory Disease of the Liver
- [ ] Leukemia
- [ ] Malignant Lymphoma
- Malignant Tumor of
  - [ ] Breast
  - [ ] Colon
  - [ ] Lung
  - [ ] Prostate
- [ ] Radiation Therapy Treatment Management
- [ ] Transplantation of Bone Marrow
- [ ] Other

_____
_____
_____
_____
_____
_____
_____

**Past Surgeries**

- [ ] None
- [ ] Excision of Basal Cell Carcinoma
- [ ] Excision of Melanoma
- [ ] Excision of Squamous Cell Carcinoma
- [ ] Other, please specify

## Skin Disease History

**Skin Conditions**

- [ ] None
- [ ] Acne
- [ ] Actinic Keratosis (pre-cancer)
- [ ] Asteatosis Cutis
- [ ] Basal Cell Carcinoma of Skin
- [ ] Contact Dermatitis due to Poison Ivy
- [ ] Dysplastic Nevus of Skin
- [ ] Eczema
- [ ] History of Asthma
- [ ] History of Hay Fever
- [ ] Malignant Melanoma
- [ ] Pruritis (itching) of Scalp
- [ ] Psoriasis
- [ ] Squamous Cell Carcinoma of Skin
- [ ] Sunburn of Second Degree
- [ ] Other

**Skin Protection**

Do you wear sunscreen? ☐ Yes ☐ No
If yes, what SPF? _____

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

**Family History of Melanoma**

Do you have a family history of Melanoma?

☐ Yes ☐ No

If so, which family members?

_____
_____
_____

## MEDICATIONS

**Please list all current medications and supplements**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

## ALLERGIES

Please list all current allergies; medications, seasonal, and environmental_____
_____
_____
_____
_____
_____
_____

## SOCIAL HISTORY

**Smoking Habits**

What is your smoking status?

- ☐ Never Smoker
- ☐ Former Smoker From _____ To _____
- ☐ Current Everyday Smoker
- ☐ Current Someday Smoker
- ☐ Current Chewing Tobacco user
- ☐ Current Vape user

**Alcohol and Drug Use**

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65? _____

Do you consume alcohol?

- ☐ None
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day

Do you use recreational drugs? ☐ Yes ☐ No

Do you use marijuana? ☐ Yes ☐ No

**Occupation**

What is your occupation? _____

What is your workplace? _____

**Residence Status**

Do you feel safe at home? ☐ Yes ☐ No

What is your place of residence? _____

## **QUALITY MEASURES** (ONLY IF YOU ARE 65 OR OLDER)

Have you received a pneumonia vaccination on or after your 60th birthday? ☐ Yes ☐ No

Do you have a healthcare proxy? ☐ Yes ☐ No

Designee's name _____ Designee's phone number _____

Do you have a living will? ☐ Yes ☐ No

Which statement(s) best reflects your wishes on advanced care recommendations?

- ☐ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.
- ☐ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.
- ☐ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

## **FAMILY HISTORY**

Please list all pertinent medical history for the following family members

- ☐ Family History Unknown
- ☐ Mother_____
- ☐ Father_____
- ☐ Sister(s)_____
- ☐ Brother(s)_____
- ☐ Paternal Aunt(s)_____
- ☐ Paternal Uncle(s)_____
- ☐ Maternal Aunt(s)_____
- ☐ Maternal Uncle(s)_____
- ☐ Paternal Grandmother_____
- ☐ Paternal Grandfather_____
- ☐ Maternal Grandmother_____
- ☐ Maternal Grandfather_____