Lisa Abernethy Christman, M.D.
DERMATOLOGY, P.A.

Patient Registration Form
Please have Photo ID and Insurance Card Ready

____
Last *First* *Middle* *Mr. Mrs. Ms. Dr.* *Nick Name*

SS#:_______-_________- ___________ Date of Birth:____/____/_____ Sex: M F Language: __________________

Race:____ Ethnic Group: ____

Place of Birth: City________________________State:_______________________________Zip:_________Country:____

Emergency Contact Full Name & Phone Number:____

Spouse Full Name & Phone Number:____

Caretaker Full Name & Phone Number:____

Home Phone:________________________Work Phone:___________________________Mobile Phone:______________

Preferred Phone: Home Work Mobile Is it ok to leave a detailed message? Yes No

Email address:_______________________________________(To send you the link for access to your **patient portal** where you can see results, update your information prior to visits, and communicate with us more easily.)

Street Address: ____
Number *Street*

____
City *State* *Zip*

Billing Address: ____

Preferred Pharmacy:_______________Address_________________________________Phone #:______________or NONE

Employer's Name:______________________________Occupation:_____________________________Industry:_______

****PRIMARY CARE PHYSICIAN*(IMPORTANT!!!)***: ____

****NAME OF HEALTH CARE PROVIDER WHO SUGGESTED THAT YOU SEE A DERMATOLOGIST:**
(IMPORTANT!!!):____

NAME OF PREVIOUS DERMATOLOGIST/PRACTICE____or NONE

Primary Insurance plan name:______________________________________ **Policy holder: self / other (circle)**

If you are <u>NOT</u> the policy holder please fill out below:
Policy holder **(if different from patient)** ____
Policy holder's date of birth:____/____/_____ SS# __________________________________
Employer of policy holder:_________________________Work Ph# _______________________
Patient's relationship to policy holder: ______________________

Secondary insurance plan name:___________________________________ **Policy holder: self / other (circle)**
Policy holder (**if different from patient**) ____
Policy holder's date of birth:____/____/_____ SS# __________________________________
Employer of policy holder:_________________________Work Ph# _______________________
Patient's relationship to policy holder: ______________________

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Authorization for Release of Protected Health Information

Patient Name (Please Print): ______________________________

How would you prefer we communicate to you your PHI (health information, labs, pathology, billing information) if you cannot be reached?

Please circle YES or NO by each of the following questions:

Is it okay to leave detailed messages with **your spouse** or **domestic partner**? **YES NO**

If YES, please provide name:______________________

If you are over 18, is it okay to leave messages with **your parents**(s)? **YES NO**

If YES, please provide name:______________________

Is it okay to leave detailed messages with **your child** over 18 years of age? **YES NO**

If YES, please provide name: ______________________

I understand that I have the right to revoke this authorization at any time. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law. I understand that I have a right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient. I have reviewed and understand this form.

Patient Signature: ______________________________ **Date:**___/___/20___

Updated 9/17 AJS

REASON FOR TODAY'S VISIT: ____

Review of Systems

(Please circle below any issues that you presently have)

Fever/chills

Bleeding issues

Anemia

Hay fever/allergies

Abnormal sun sensitivity

Joint inflammation/pain

Autoimmune problems

Increased risk infection/immunosuppression

NONE

Alerts

(Please circle all that apply)

Blood thinners

Low platelet count

Problems with scarring

Allergy to adhesive (bandages)

Allergy to latex gloves

Allergy to lidocaine

Rapid heartbeat with epinephrine

Allergy to topical antibiotic ointments

Hepatitis B or C history

HIV/AIDS

MRSA

Artificial heart valve

Premedication prior to procedures

Defibrillator

Pacemaker

Faint easily

Raynaud's disease (blue/white fingers in cold)

Glaucoma

History of malignant melanoma

Pregnant

Attempting pregnancy

Breast feeding

Breast implants

Lymph node dissection

NONE

******YOU MAY SKIP ANY PORTION OF THIS PACKET THAT YOU HAVE FILLED OUT ON THE PATIENT PORTAL******

History and Intake Form

Past Medical History: (please circle all that apply; circle **NONE** at the bottom if none apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
  Are you on insulin? Y or N
End Stage Renal Disease
Esophageal Reflux
Hearing Loss
Hepatitis (A, B, or C?)
Hypertension
HIV / AIDS
Hypercholesterolemia
Hyperthyroidism (history of high thyroid)
Hypothyroidism (history of low thyroid)
Inflammatory Bowel Disease
Leukemia
Liver Problems: ____________________
Lung cancer
Lupus
Lymphoma
Prostate Cancer
Radiation Treatment
Rheumatoid Arthritis
Seizures
Stroke
Valve Replacement
NONE

Other Major Health Issues: ____

Past NON-Dermatologic Surgical History: (please circle all that apply; circle **NONE** if none apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA (Angioplasty)
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement: Knee (Right, Left, Both)
Joint Replacement: Hip (Right, Left, Both)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
NONE

Other Major Surgical History: ____

Skin Disease History: (please circle all that apply; circle **NONE** if none apply)

Skin Cancer:	Basal Cell Carcinoma Squamous Cell Carcinoma Malignant Melanoma Abnormal Mole (biopsy-proven) Actinic Keratosis (pre-cancers) **NONE**
Other Skin Issues:	Blistering Sunburns Eczema Fever Blisters Psoriasis Rosacea Other: ____________________

Do you wear sunscreen? **YES** **NO**

If yes, what SPF? ______________

Family History:

Has a parent, sibling, or child ever had a malignant melanoma? **YES** **NO**

(a *melanoma is a dark mole that requires a large excision*)

If yes, circle : mother father sister brother child

Medications: (please attach or list all current medications with doses if known) / **NONE (circle if applies)**

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Allergies: (please list all allergies to oral medications) / **NONE (circle if applies)**

____

Social History: (Please circle all that apply)

Cigarette Smoking:	Never smoked Quit: Former smoker Smokes less than daily Smokes daily
Alcohol Use:	Alcohol: none Alcohol: less than 1 drink a day Alcohol: 1-2 drinks a day Alcohol: 3 or more drinks a day
IF OVER 65:	Have you had a pneumonia vaccine? **Yes** **No**

Occupation: ____

If retired, previous occupation: ____________________________

Dr. Christman does not perform cosmetic procedures (except removal of benign lesions). Circle below if you are interested in receiving information regarding referral for any of the following services:

Skin Care Products | Facial Peels | Laser Hair Removal | Facial Vessels | Leg Veins | Botox | Fillers