

WELCOME TO OUR OFFICE. PLEASE TAKE A MOMENT TO COMPLETE THIS FORM IN ITS ENTIRETY.

LAST NAME		FIRST	INT	SEX M F	D.O.B.	
STREET ADDRESS			CITY/ STATE/ ZIP		HOME PHONE	CELL PHONE
PATIENT'S OR PARENT'S EMPLOYER			OCCUPATION (INDICATE IF STUDENT)		BUSINESS PHONE	
DO YOU HAVE A PRIMARY CARE PHYSICIAN? Y N						
IF YES, WHO?						
SPOUSE'S EMPLOYER			OCCUPATION		BUSINESS PHONE	
EMAIL ADDRESS:			REFERRED BY: HOW DID YOU HEAR ABOUT OUR OFFICE?			

PERSONAL INFORMATION

INSURANCE INFORMATION

INSURED /PARTY RESPONSIBLE	ADDRESS (IF DIFFERENT FROM PATIENT)	RELATIONSHIP	INSURED'S DATE OF BIRTH
			SS# IF NECESSARY)
PRIMARY INSURANCE COMPANY	GROUP NUMBER	MEMBER ID NUMBER	
SECONDARY INS COMPANY/ NAME OF INSURED	GROUP NUMBER	MEMBER ID NUMBER	

PREFERRED PHARMACY	LOCATION	PHONE NO (IF AVAILABLE)
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EMERGENCY CONTACTS

PLEASE LIST BELOW SOMEONE WE MAY CONTACT IN CASE OF AN EMERGENCY

NAME	PHONE NUMBER	RELATIONSHIP
NAME	PHONE NUMBER	RELATIONSHIP

CURRENT PROBLEM

BRIEFLY STATE YOUR PROBLEM. DO YOU HAVE ANY SYMPTOMS LIKE BURNING OR ITCHING ASSOCIATED WITH IT?		
HOW LONG HAVE YOU HAD THIS?	HAVE YOU HAD IT BEFORE? IF SO, WHEN	HAVE YOU BEEN TREATED FOR THIS BEFORE?

HISTORY AND INTAKE FORM

Past Medical History:

- | | | |
|--|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> GERD | <input type="checkbox"/> Other Cancer _____ |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> BPH | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Bone Marrow Transplant | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Hypercholesterolemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Valve Replacement |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hypothyroidism | |

Other _____

Past Surgical History:

- | | |
|---|---|
| <input type="checkbox"/> Appendix Removed | <input type="checkbox"/> Kidney Biopsy |
| <input type="checkbox"/> Bladder Removed | <input type="checkbox"/> Kidney Removed (Right, Left) |
| <input type="checkbox"/> Mastectomy (Right, Left, Bilateral) | <input type="checkbox"/> Kidney Stone Removal |
| <input type="checkbox"/> Lumpectomy (Right, Left Bilateral) | <input type="checkbox"/> Kidney Transplant |
| <input type="checkbox"/> Breast Biopsy (Right, Left, Bilateral) | <input type="checkbox"/> Ovaries Removed: Endometriosis |
| <input type="checkbox"/> Breast Reduction | <input type="checkbox"/> Ovaries Removed: Cyst |
| <input type="checkbox"/> Breast Implants | <input type="checkbox"/> Ovaries Removed: Ovarian Cancer |
| <input type="checkbox"/> Colectomy: Colon Cancer Resection | <input type="checkbox"/> Prostate Removed: Prostate Cancer |
| <input type="checkbox"/> Colectomy: Diverticulitis | <input type="checkbox"/> Prostate Biopsy |
| <input type="checkbox"/> Colectomy: IBD | <input type="checkbox"/> TURP |
| <input type="checkbox"/> Gallbladder Removed | <input type="checkbox"/> Skin Biopsy |
| <input type="checkbox"/> Coronary Artery Bypass | <input type="checkbox"/> Basal Cell Cancer Surgery |
| <input type="checkbox"/> PTCA | <input type="checkbox"/> Squamous Cell Carcinoma Surgery |
| <input type="checkbox"/> Mechanical Valve Replacement | <input type="checkbox"/> Melanoma Surgery |
| <input type="checkbox"/> Biological Valve Replacement | <input type="checkbox"/> Spleen Removed |
| <input type="checkbox"/> Heart Transplant | <input type="checkbox"/> Testicles Removed (Right, Left, Bilateral) |
| <input type="checkbox"/> Joint Replacement, Knee | <input type="checkbox"/> Hysterectomy: Fibroids |
| <input type="checkbox"/> Joint Replacement within last 2 yrs | <input type="checkbox"/> Hysterectomy: Uterine Cancer |

Other _____

Family History:

- | | | |
|--|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> GERD | <input type="checkbox"/> Other Cancer _____ |
| <input type="checkbox"/> BPH | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Hypercholesterolemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hyperthyroidism | |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hypothyroidism | |

Other _____

Are you currently pregnant? Yes No If yes, how long? _____

Number of Pregnancies _____ Miscarriages _____

Are you post- menopausal? Yes No If yes, how long? _____

Skin Disease History:

- | | | |
|---|---|---|
| <input type="checkbox"/> Actinic Keratoses | <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> Squamous Cell Skin |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Melanoma | <input type="checkbox"/> None |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Poison Ivy | |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Precancerous Moles | |

Other: _____

Do you wear sunscreen daily: Yes No If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a **family history** of: Melanoma If so, which relative(s)? _____
 SCC/BCC If so, which relative(s)? _____

MEDICATIONS: (Please list all current medications)

SUPPLEMENTS: (Please list all current supplements)

ALLERGIES: (Please enter all allergies)

SOCIAL HISTORY:

- | | |
|---|--|
| <input type="checkbox"/> Currently Smokes – daily | <input type="checkbox"/> Alcohol Use: _____ Daily _____ Social |
| <input type="checkbox"/> Currently Smokes – not daily | <input type="checkbox"/> Illicit Drug Use |
| <input type="checkbox"/> Previous Smoker - Year Stopped _____ | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Never smoked | |
- Other _____

REVIEW OF SYSTEMS (PLEASE CHECK ALL THAT APPLY):

- | | | |
|---|--|--|
| <input type="checkbox"/> Problems with bleeding | <input type="checkbox"/> Cough | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Problems with healing | <input type="checkbox"/> Depression | <input type="checkbox"/> Unintentional weight loss |
| <input type="checkbox"/> Problems with scarring (hypertrophic/keloid) | <input type="checkbox"/> Fever or chills | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Immunosuppression | <input type="checkbox"/> Headaches | |
| <input type="checkbox"/> Changing mole | <input type="checkbox"/> Hay fever | |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Joint aches | |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Muscle weakness | |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Neck stiffness | |
| <input type="checkbox"/> Blood stool | <input type="checkbox"/> Night sweats | |
| <input type="checkbox"/> Bloody urine | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Shortness of breath | |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Sore throat | |

PATIENT SIGNATURE _____ **DATE** _____

DR ROSE _____ **DATE** _____

PLEASE READ CAREFULLY

I UNDERSTAND THAT DR. ROSE DERMATOLOGY PARTICIPATES WITH CERTAIN INSURANCE CARRIERS. UNLESS A CONTRACTUAL ARRANGEMENT EXISTS BETWEEN DR. ROSE AND MY INSURANCE COMPANY, I AGREE TO PAY THE FEES IN FULL, EVEN THOUGH THE AMOUNT MAY BE GREATER THAN WHAT I AM ENTITLED TO RECEIVE FROM MY INSURANCE CARRIER. ANY CO/PAYS, DEDUCTIBLES, OR AMOUNTS DEEMED PAYABLE BY MY INSURANCE CARRIER SHALL BE MY RESPONSIBILITY. BALANCES REFLECTED ON THE OFFICE BILL, WHICH IS NOT EXPECTED TO BE REIMBURSED BY INSURANCE, SHALL BE PAYABLE BY ME. PROCEDURES DEEMED "COSMETIC", BY ANY INSURANCE CARRIER, WILL BE MY RESPONSIBILITY. THERE IS A \$25.00 FEE FOR ALL UNPAYABLE CHECKS. *IT IS YOUR RESPONSIBILITY TO BE FAMILIAR WTH YOUR INSURANCE POLICY FOR GENERAL COVERAGE ISSUES.*

SIGNATURE _____ DATE _____

AN IMPORTANT MESSAGE REGARDING MOLES AND MELANOMAS

THE INCIDENCE OF MALIGNANT MELANOMA IS ON THE RISE. IN EFFORT TO IDENTIFY AND TREAT THIS CONDITION, IT IS RECOMMENDED THAT A TOTAL SKIN OR DERMATOLOGICAL BODY EXAM BE PERFORMED. BY VISUAL EXAMINATION OF MOLES, ON THE SKIN, WE CAN EVALUATE THE STATUS OF THOSE LESIONS AND DETERMINE IF TREATMENT IS NEEDED AT THIS TIME,

NO ONE KNOWS WHAT THE STIMULUS IS FOR SUCH LESIONS TO UNDERGO MALIGNANT CHANGES. VARIOUS FACTORS SUCH AS SPORADIC SUN BURNS, PROLONGED SUN EXPOSURE, TRAUMA, FRICTION, HORMONAL INFLUENCES AND HEREDITY HAVE BEEN INVOLVED IN THE DEVELOPMENT OF MALIGNANT CHANGES (CALLED MELANOMA). BECAUSE OF THE RAPID EVOLUTION OF MELANOMAS, IT IS OF THE UTMOST IMPORTANCE THAT QUICK AND EARLY DIAGNOSIS BE MADE. TREATMENT MUST BE DONE TO REMOVE SUCH A LESION ENTIRELY AND THOROUGHLY. CURRENTLY, PROGRESS IS BEING MADE IN THE CHEMICAL TREATMENT OF THOSE PATIENTS WHOSE DISEASE HAS SPREAD TO OTHER PARTS OF THE BODY; HOWEVER THE BEST HOPE IS FOR EARLY DIAGNOSIS AND REMOVAL.

DERMATOLOGISTS ARE TRAINED TO CLINICALLY RECOGNIZE THE TYPES OF CHANGES THAT TAKE PLACE IN MELANOMA AND ARE KNOWLEDGEABLE OF THE MICROSCOPIC ASPECTS OF THIS CONDITION. APPROACHES IN TREATMENT OF SUCH LESIONS ARE IN THE FOREFRONT OF GOOD DERMATOLOGICAL PRACTICE. ANY CHANGE WHATSOEVER IN A MOLE SHOULD BE CAREFULLY EVALUATED BY A DERMATOLOGIST.

ACCORDINGLY, THIS DERMATOLOGICAL PRACTICE IS OFFERING TO PATIENTS TOTAL BODY DERMATOLOGICAL EXAMINATION WITH APPROPRIATE RECOMMENDATIONS. THIS WILL INCLUDE A FULL HEAD-TO-TOE SURVEY OF THE ENTIRE SKIN. ANY SUSPICIOUS LESIONS CAN AND WILL BE REMOVED. THAT TISSUE WILL BE SENT FOR HISTOLOGICAL EXAMINATION BY A BOARD CERTIFIED DERMOPATHOLOGIST WHO WILL BILL YOU DIRECTLY. THE USUAL SURGICAL FEES WILL BE APPLIED FOR SUCH SERVICES IN THIS OFFICE.

ON THIS VISIT TO OUR OFFICE TODAY WE EXTEND TO YOU THE OPPORTUNITY TO HAVE THE ABOVE NOTED DERMATOLOGICAL EXAMINATION PERFORMED ON YOU. BECAUSE OF THE IMPORTANCE OF THIS VERY SERIOUS CONDITION, WE RECOMMEND THAT IT BE DONE.

PLEASE SIGN AND DATE THIS FORM ACKNOWLEDGING WHETHER OR NOT YOU WISH TO HAVE THIS PROCEDURE PERFORMED.

_____ YES, I WISH TO HAVE THE EXAMINATION PERFORMED.

_____ NO, I DO NOT WISH TO HAVE THE EXAMINATION PERFORMED.

SIGNATURE

DATE