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 FROMPATIENT)	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)

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:

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

Other _____

Past Surgical History:

- ☐ 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
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement, Knee
- ☐ Joint Replacement within last 2 yrs
- ☐ 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
- ☐ TURP
- ☐ Skin Biopsy
- ☐ Basal Cell Cancer Surgery
- ☐ Squamous Cell Carcinoma Surgery
- ☐ Melanoma Surgery
- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Bilateral)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer

Other _____

Family History:

- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Other Cancer _____
- ☐ Prostate Cancer
- ☐ Seizures
- ☐ Stroke

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:

- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Acne
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Eczema
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Squamous Cell Skin Cancer
- ☐ Psoriasis
- ☐ None

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:

- ☐ Currently Smokes – daily
- ☐ Currently Smokes – not daily
- ☐ Previous Smoker - Year Stopped _____
- ☐ Never smoked
- ☐ Alcohol Use: _____ Daily _____Social
- ☐ Illicit Drug Use
- ☐ NONE

Other _____

REVIEW OF SYSTEMS (PLEASE CHECK ALL THAT APPLY):

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

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 DEVELOPMENTOF 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.

DERMATOLGISTS 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 DERMOPATHOLGIST WHO WILL BILL YOU DIRECTLY. THE USUAL SUGICAL 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 ACKNOWLEDING 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