SKIN SPECTRUM, P.C.

6127 N. La Cholla Blvd., Suite 101, Tucson, AZ 85741
Phone: 520-797-8885 Fax: 520-797-1912

PATIENT REGISTRATION

First Name:_____ Last Name: _____ MI:_____

Mailing Address: _____

City: _____ ST: _____ ZIP: _____

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

Cell Phone: (_____)-_____-_____ Birthdate:___/___/___ Gender: M____F____

Preferred Contact Number: Home____Cell____Work____

EMail Address:_____

Employer:_____ Occupation:_____

Marital Status: S____M____D____W____ Name of Spouse:_____

Emergency Contact:_____Relation:_____

Phone: (_____)-_____-_____

How were you referred to us?:_____

Cosmetic Consultations and Procedures are **exempt** and not covered by any insurance carriers. I acknowledge and understand that I am financially responsible for all services rendered to me at the conclusion of the visit. As a parent or guardian, I am financially responsible for any services rendered to the above patient at the conclusion of the visit.

Patient Signature:_____ Date:_____
Parent/Guardian Signature:_____ Date:_____

- May we send you our monthly specials via Email? Yes____No____
- May we leave appointment reminders? Yes____No____ Please Circle One: Text/ Call
- May we use your photos for patient education? Yes____No____

HIPAA CONSENT

Skin Spectrum is not authorized to disclose any of your information to anyone other than you without your prior written consent. Please carefully read the following, check the appropriate boxes and sign and date at the bottom

I _____ authorize

(Print your name)

_____to conduct any or all of the following on my behalf:

(Name of person(s) you wish to authorize)

☐ To request my payment history: Year(s) _____

☐ To schedule, cancel, and/or confirm my appointments.
(Skin Spectrum may need to disclose your treatment plan to adequately schedule.)

☐ To place prescription requests, as well as discuss any concerns or questions regarding any medications prescribed to me.

☐ To allow the purchase of any procedures or products related to my account.
(Please note that we may disclose billing information, as well as previous product or treatment purchases and recommendations given to you during office visits.)

☐ I do not authorize any other person other than myself .

***This authorization shall remain in effect until revoked in writing by the requesting individual.**

Signature:_____**Date:**_____

Date of Birth:_____

Patient Name: _____ Date: _____

Date of birth: _____

Skin

[ ] None
[ ] Atypical Moles
[ ] Precancer (actinic keratosis)
[ ] Squamous Cell Carcinoma
[ ] Melanoma
[ ] Abnormal scarring/Keloid
[ ] Psoriasis
[ ] Eczema
[ ] Other_____

Infections

[ ] None
[ ] Hepatitis A
[ ] Hepatitis B
[ ] Hepatitis C
[ ] HIV/AIDS
[ ] Tuberculosis/ TB
[ ] Other_____

Immune

[ ] None
[ ] Lupus
[ ] Organ Transplant
[ ] Cancer Chemotherapy
[ ] Other_____

Hematologic/Lymphatic

[ ] None
[ ] Slow to heal after cuts
[ ] Easily bruise or bleed
[ ] Anemia
[ ] Phlebitis
[ ] Past Transfusion
[ ] Enlarged glands/lymph nodes
[ ] Other_____

Eye, Ear, Nose, Throat

[ ] None
[ ] Glaucoma
[ ] Hearing Aid
[ ] Plastic Surgery_____
[ ] Other_____

Are you currently pregnant?
Yes No N/A

Psychiatric

[ ] None
[ ] Memory loss or confusion
[ ] Depression
[ ] Sleep problems
[ ] Anxiety
[ ] Dementia
[ ] Other _____

Constitutional

[ ] None
[ ] Good general health lately
[ ] Recent weight gain
[ ] Recent weight loss
[ ] Fever
[ ] Chills
[ ] Fatigue
[ ] Headaches
[ ] Other_____

Gastrointestinal

[ ] None
[ ] Stomach Ulcer
[ ] Colitis
[ ] Liver Problems
[ ] Other_____

Urological

[ ] None
[ ] Dialysis
[ ] Kidney Problems
[ ] Venereal Disease
[ ] Other_____

Respiratory

[ ] None
[ ] Frequent coughing
[ ] Asthma or wheezing
[ ] Emphysema
[ ] Other_____

Are you planning to get pregnant
In the future?
Yes No Unsure N/A

Cardiovascular

[ ] None
[ ] Heart attack
[ ] Chest Pains
[ ] Sudden heart beat changes
[ ] Swelling of feet, ankles,hands
[ ] Pacemaker
[ ] Artificial Heart Valve
[ ] Other_____

Endocrine

[ ] None
[ ] Glandular/ hormone problem
[ ] Thyroid Disease
[ ] Oral steroid use
[ ] Diabetes
[ ] Other_____

Neurological

[ ] None
[ ] Stroke
[ ] Seizure (epilepsy)
[ ] Neuralgia
[ ] Myasthenia Gravis
[ ] ALS
[ ] Numbness/ Tingling
[ ] Migraines
[ ] Other_____

Musculoskeletal

[ ] None
[ ] Joint Pain
[ ] Joint stiffness or swelling
[ ] Weakness of muscles/ joints
[ ] Back Pain
[ ] Difficulty walking
[ ] Artificial joints
[ ] Fibromyalgia
[ ] Arthritis
[ ] Other_____

List all Surgeries and Date of Occurrence: Circle "none" if it applies

None

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

List all Serious Illness and /or Accidents and Date of Occurrence: Circle "none" if it applies

None

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

List all Allergies: Medications, Food, Latex, etc.
Circle "none" if it applies

None	Type of Reaction (i.e. rash, anaphylaxis)
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____

List all Current Medications/Supplements: Circle "none" if it applies

None

Med/Supplement	Dose	Timing (i.e. 2x/day)
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____
7._____	_____	_____
8._____	_____	_____
9._____	_____	_____
10._____	_____	_____

Current Vitamins/ Minerals/Supplements
(Circle all that apply)

None	Calcium
Vit. B	Multivitamin
Vit. C	Herbal supplements
Vit. D	Chinese Herbs
Vit. E	Fish Oils (Omega 3)
Vit. K	Natural Hormones

Current usage of Non-Steroidal Anti-inflammatory drugs (i.e. Motrin, Aleve, Ibuprofen

None Daily Weekly Rarely

Current usage of Aspirin:

None Daily Weekly Rarely

Patient Name: _____ Date: _____

Date of birth: _____

Family History			**Afflicted Family Member/ Details**
Basal cell/ Squamous cell cancer	N	Y	_____
Increased number of moles/ atypical moles	N	Y	_____
Melanoma	N	Y	_____
Abnormal Bleeding	N	Y	_____
Autoimmune disorders	N	Y	_____
Cancer	N	Y	_____
Diabetes	N	Y	_____
Drug Allergies	N	Y	_____
Endocrine Disease	N	Y	_____
Heart Disease	N	Y	_____
High Blood Pressure	N	Y	_____
Skin Disease	N	Y	_____
Substance Abuse	N	Y	_____

Smoking History: circle all that apply

Never

Packs per Day	Length	Quit
<1 pack per day	for <5 years	quit <1 year ago
1 pack per day	for 5-10 years	quit 1-5 years ago
2 pack per day	for 10-15 years	quit 5-10 years ago
3 pack per day	for 15-20 years	quit 15-20- years ago
4 pack per day	for 20-25 years	quit >20 years ago
4+ packs per day		

Alcohol Usage: Circle One

None
Occasional (1-2 drinks)
Social (1-2 drinks)
Daily (1-2 drinks)
Daily (2-5 drinks)
Daily (>5drinks)

Skin Type/Color (Fitzpatrick Classification): Circle One

Very White or Freckled (I)
White (II)
White to Olive (III)
Brown (IV)
Dark Brown (V)
Black (VI)

Skin Questionnaire

Do you tan easily?	Y	N
Do you burn easily?	Y	N
Do you have sun damaged skin?	Y	N
Are you willing to wear sunscreen daily?	Y	N
Are you outdoors frequently?	Y	N
Do you wear make-up frequently?	Y	N
Are you on a daily skin care program?	Y	N
Have you been on Accutane in last 12 months?	Y	N
Do you bruise easily?	Y	N
Do you have permanent make-up?	Y	N
Do you scar abnormally, i.e. keloid scar?	Y	N

SKIN
Spectrum

THE ART & SCIENCE OF DERMATOLOGY

I have read or received a copy of Skin Spectrum's Notice of Privacy Practices.

_____

Printed Name

_____ _____

Signature Date