1539 Atwood Avenue
Suite 301
Johnston RI 02919

Coastal Dermatology and cosmetic center

Phone: 401-490-4515
Fax: 401-490-4516
Web: www.coastaldermri.com

# Patient Registration Form

**Welcome! Thank you for choosing Coastal Dermatology & Cosmetic Center.**
**Please completely fill out this form to ensure the fastest and best healthcare service.**

Patient Name: ______________________________ Sex: M_______ F_______ Date: _______/_______/________

Birthdate: ______/______/______ SSN: ______________Marital Status: Married_______ Single_______ Divorced______ Widow______

Language Preference: [ ]English [ ]Spanish [ ]Portuguese [ ]Italian [ ]Chinese [ ]French [ ]Decline to answer [ ]Other_______

Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Decline to answer [ ] Other________________

Race: [ ] Caucasian [ ] Hispanic or Latino [ ] African American [ ] American Indian [ ] Alaskan Native [ ] Native Hawaiian

[ ] Asian [ ] Decline to answer [ ] Other______________________

Home Address: ______________________________City: __________________ State: _______ Zip: ___________

Telephone: home______________________ Cell______________________ Work______________________ Email: ______________________

Employer: ______________________________ Occupation: ______________________________

Employer's Address: ______________________________ City: __________________ State: _______ Zip: ______________

Primary Physician: ______________________________ Phone #: ____________________Fax #: ______________________

Referring Physician: ______________________________ Phone #: ____________________Fax #: ______________________

Pharmacy: ______________________________ Pharmacy Phone: ______________________________

Pharmacy Address: ______________________________ City: ____________________ State: ______ Zip: __________

Emergency Contact: ______________________________ Relationship: ____________________Phone #: ________________

**Insurance Information:**

Primary Insurance: ______________________________ Secondary Insurance: ______________________________

Subscriber's Name: ______________________ DOB:__________ Subscriber's Name: ______________________ DOB:___________

Group#: ____________________ Policy#: ____________________ Group#: ____________________ Policy#: ____________________

I consent to treatment necessary for care of the above named patient. I authorized the release of all medical records to the referring family physician and to my insurance company. If applicable, I allow fax transmittal of my medical records. If necessary, I acknowledge full financial responsibility for services rendered by Coastal Dermatology & Cosmetic Center, Inc. If my insurance does not pay for all or part of the services rendered to me by physician I understand that I am fully responsible for payment of all services. I understand that full payment/co-payment are due at the time of service unless other definite financial arrangements have been made prior to treatment. I future authorize and request that insurance payments be made directly to Coastal Dermatology & Cosmetic Center, Inc. should they elect to receive such payments. I have read and fully understand the above consent of treatment, financial responsibility and insurance authorization.

**Patient/Legal Guardian Signature: ______________________________ Date: ________________**

**I consent to give my permission for photography to be used for comparison of the treatment results and medical records.**

**Patient/Legal Guardian Signature: ______________________________ Date: ________________**

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# The New Patient Intake Form

**Patient Name:**_______________________________________________ **Date of Birth:**___________________

**What is the reason for your visit today?**_____________________________________________________

**Allergies**: __________________________________________________________________________

**Current medications (prescription and non-prescription medications):**

| Medication | Dose | How often | Medication | Dose | How often |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Are you currently taking the following blood thinner?**
[ ] Aspirin [ ] Coumadin [ ] Plavix [ ] Xarelto
[ ] NSAIDS (i.e. ibuprofen/motrin/advil/alleve/naprosyn)
[ ] Others: ____________________________________________________________________________

**Are you currently taking the following?**
[ ] Fish oil [ ] Gingko [ ] Garlic [ ] St. John's wart [ ] Vitamin E
[ ] Others: ____________________________________________________________________________

**Do you have following alert conditions?**
[ ] Allergy to Adhesive
[ ] Allergy to topical antibiotics
[ ] Artificial Joints within past 2 years
[ ] Defibrillator
[ ] MRSA
[ ] Premedication prior to procedures
[ ] Pregnancy or planning a pregnancy
[ ] Yeast Infections with Antibiotics
[ ] Allergy to lidocaine
[ ] Artificial heart valve
[ ] Blood thinners
[ ] GI Upset with Antibiotics
[ ] Pacemaker
[ ] Rapid heart beat with epinephrine
[ ] West Africa: travel or contact
[ ] Others: ____________________________________________________________________________

**Past Medical History:**
[ ] Anxiety [ ] Arthritis [ ] Asthma [ ] A Fib [ ] bone marrow transplantation [ ] Bleeding Dz
[ ] BPH [ ] Breast Ca [ ] Colon Ca [ ] COPD [ ] Coronary artery Dz [ ] Depression
[ ] Diabetes [ ] ESRD [ ] Eye Disease [ ] GERD [ ] Hearing loss [ ] Hepatitis
[ ] High BP [ ] HIV/AIDS [ ] ↑Cholesterol [ ] ↑ Thyroid [ ] ↓Thyroid [ ] IBD
[ ] Kidney Dz [ ] Leukemia [ ] Lung Ca [ ] Lymphoma [ ] Organ Transplant [ ] Prostate Ca
[ ] Pneumonia [ ] Rheumatic Fever [ ] Seizures [ ] Stroke
[ ] Other_______________________________________________________________________________

**Past Surgeries**:
[ ] Appendix Removed
[ ] Breast Removed (R/L/B)
[ ] Breast Biopsy(R/L/B)
[ ] Colon (Colectomy): IBD
[ ] Gallbladder Removed
[ ] Heart: Mechanical Valve Replacement
[ ] Heart Transplant
[ ] Heart: Pacemaker
[ ] Joint Replacement: Hip (L/R/B)
[ ] Kidney Stone Removed
[ ] Kidney Transplant
[ ] Liver: Hepatectomy
[ ] Bladder Removed
[ ] Breast: Lumpectomy (R/L/B)
[ ] Colon (Colectomy): Colon Cancer Resection
[ ] Colon (Colectomy): Diverticulitis
[ ] Heart: Biological Valve Replacement
[ ] Heart: Coronary Artery Bypass
[ ] Heart: PTCA (Stent/Angioplasty)
[ ] Heart Transplant
[ ] Joint Replacement: Knee (L/R/B)
[ ] Kidney Nephrectomy
[ ] Kidney Biopsy
[ ] Liver: Liver Transplant

[ ] Liver: Shunt
[ ] Ovaries: Tubal Ligation
[ ] Prostate Removed
[ ] Skin: Basal Cell Ca
[ ] Skin: Squamous Cell Ca
[ ] Testicles (Orchiectomy)
[ ] Uterus (Hysterectomy): Uterine Ca
[ ] Ovaries Removed
[ ] Pancreas Removed
[ ] Prostate Biopsy
[ ] Skin: Melanoma
[ ] Spleen Removed
[ ] Uterus (Hysterectomy): Fibroids
[ ] Uterus (Hysterectomy): Cervical Ca
[ ] Other______________________________________________________________________________________

**Skin Disease History**:
[ ] Acne [ ] Actinic Keratoses [ ] Blistering Dz [ ] Dry Skin [ ] Eczema
[ ] Flaking Scalp [ ] Hay Fever/Allergies [ ] Basal Cell Ca [ ] Squamous Cell Ca [ ] Melanoma
[ ] Mole [ ] Psoriasis [ ] Rash [ ] Sunburns
[ ] Other:_____________________________________________________________________________________

**Family History:**
[ ] Melanoma. Relatives: ______________________________________________________________________
[ ] Basal Cell Carcinoma. Relatives: ____________________________________________________________
[ ] Squamous Cell Carcinoma. Relatives: _________________________________________________________
[ ] Hay Fever/Allergies. Relatives: ______________________________________________________________
[ ] Precancerous Moles. Relatives: ______________________________________________________________
[ ] Psoriasis. Relatives: _______________________________________________________________________
[ ] Connective Tissue Disease. Relatives: _________________________________________________________
[ ] Other (please specify)_______________________________________________________________________

**Social History:**
[ ] Never Smoker [ ] Unknown if ever smoked [ ] Current Smoker [ ] Former Smoker
[ ] None Alcohol [ ] Less than 1 drink/day [ ]1-2 drinks per day [ ] 3 or more drinks per day
[ [ Not sexually active [ ] Same sex partner [ ] Sexually active w/ more than 1 partner
[ ] Drug use [ ] IV drug use [ ] Pt feels safe at home [ ] Pt feels unsafe home

**Review of Systems:**
**Constitutional Symptoms:**
[ ] Recent weight change [ ] fever/chills [ ] Fatigue

**Cardiovascular System:**
[ ] Chest pain [ ] bleeding disorders

**Gastroenterology system:**
[ ] Abdominal pain [ ] N/V/D [ ] Constipation [ ] Heart burn
[ ] Rectal bleeding [ ] Hepatitis [ ] Abnormal LFT

**Musculoskeletal System:**
[ ] Joint pain [ ] Muscle pain

**Respiratory System:**
[ ] Shortness of breath [ ] Coughing/wheezing

**Neurological System:**
[ ] Headache [ ] Seizure

**Psychiatric System:**
[ ] Memory Loss [ ] Confusion [ ] Depression [ ] Anxiety

**Endocrine System:**
[ ] Excessive Thirst [ ] Excessive Urination [ ] Heat Intolerance [ ] Cold Intolerance

**Immunology (Allergy) System:**
[ ] Hives [ ] Itching

**Ears/Nose/Mouth/Throat:**
[ ] Mouth Sores

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**Skin:**
[ ] Chronic Eczema [ ] Chronic leg Ulcers [ ] Connective Tissue Dz [ ] Psoriasis [ ] Rash
[ ] Vitiligo

**Do You have Up-To-Date Immunizations?**
[ ] Influenza (Flu shot) [ ] Pneumonia Vaccine [ ] Herpes Zoster Vaccine (Singles)
[ ] Other (Please specify)________________________________________________________________________________

**Certification of patient information:**
I certify that all information provided on this date to *Coastal Dermatology and Cosmetic Center* is correct.

**Signature of Patient or Responsible Party:** ______________________________________________**Date:**_____________

**Legal Representative's Relationship to Patient:** __________________________________________**Date:**_____________