Patient Registration Form

Southwest Dermatology & Vein

PATIENT INFORMATION

Last Name	First Name	Middle Initial

Date of Birth	Birth Sex	Language

Race (Circle One) White | Black | Latino | Other_____ | Decline to Specify	Marital Status	Social Security Number

Home Phone	Work Phone	Mobile Phone

Preferred Phone (Circle One) Home | Work | Mobile	Email Address

Street Address	Apt #	City	State	Zip Code

GUARANTOR- PARENT, SPOUSE OR RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

Patient's Relationship to Guarantor (Circle One)
Self | Spouse | Child | Other | Employee (If selecting self, skip to Preferred Pharmacy)

Guarantor Last Name	Guarantor First Name	Guarantor Date of Birth

Guarantor Street Address	Apt #	City	State	Zip Code

Guarantor Phone	Guarantor Email

PREFERRED PHARMACY

Pharmacy Name	Pharmacy Address	Pharmacy Phone

ADDITIONAL PROVIDER/REFERRAL INFORMATION

Referring Provider	Primary Care Physician (PCP)

How did you hear about our clinic? (Circle One)
Family/Friend | Facebook | Yelp | Google | Print Ad | Post Card | Other:_____

INSURANCE INFORMATION

Primary Insurance Carrier	Primary Insurance Policy/ID #	Primary Insurance Group #
Primary Insurance Policy Holder's Name	Primary Insurance Policy Holder's D.O.B.	Patient's Relationship to Insured
Secondary Insurance Carrier	Secondary Insurance Policy/ID #	Secondary Insurance Group #
Secondary Insurance Policy Holder's Name	Secondary Insurance Policy Holder's D.O.B.	Patient's Relationship to Insured

LEGAL INFORMATION

Consent for Communication: I understand Southwest Dermatology & Vein Clinic will send appointment reminders and information on services via telephone, email and/or text message based on the contact information I have provided. I understand that I will have the option to opt out of future text/email reminders. _____**(Initials)**

Legal: This form applies to Southwest Dermatology & Vein Clinic and its related companies including but not limited to; Southwest Dermatology, Southwest Skin Cancer & Vein Clinic and Southwest Skin and Vein Center PLLC. _____**(Initials)**

Signature: _____ **Date:** _____

Parent/Legal Guardian: _____ **Date:** _____

Medical History and Intake Form

Southwest Dermatology & Vein

Patient Name: _____ **Date of Birth:** _____

Preferred Name: _____

□ **The clinic can discuss my care with:** _____
Name Relation Phone

□ **The clinic may leave a detailed message regarding medications or lab results.**

Past Medical History: (Check all that apply. If NONE, please check NONE)

□ Anxiety Disorder	□ Cancer*	□ High Blood Pressure	□ Hyperthyroidism
□ Arthritis*	□ Stroke	□ Kidney Disease*	□ Hypothyroidism
□ Asthma	□ Lung Disease*	□ Psychiatric Disease*	□ Myasthenia Gravis
□ Atrial Fibrillation	□ Depression	□ Heart Disease*	□ Gastrointestinal Disease*
□ Autoimmune Disease*	□ Diabetes Mellitus	□ Radiation	□ Vein Disease
□ Bone Marrow Transplant	□ Cervical Dysplasia	□ High Cholesterol	□ **NONE**

***Please list type/Other:** _____

Past Surgical History (Please list any prior non-skin related surgeries): □ **See List**

_____ _____ _____

Skin Disease History:

□ Acne	□ Dysplastic Nevus	□ Melanoma	□ Squamous Cell Carcinoma
□ Basal Cell Carcinoma	□ Eczema	□ Psoriasis	□ Family History of Melanoma

Other skin cancers: _____ Other skin disease: _____

Alerts:

□ Pregnancy	□ Pacemaker	□ Artificial Joints <2 yrs old	□ HIV
□ Breastfeeding	□ Defibrillator	□ Need Antibiotics for Procedures	□ Hepatitis B
□ Allergy to Adhesive	□ Brain/Spinal Stimulator	□ Immunosuppression	□ Hepatitis C
□ Allergy to Latex	□ Artificial Heart Valve	□ Organ Transplant	□ Blood Thinners

Cosmetics (Check any you have interest in):

□ Botox/Dysport	□ Fillers	□ Microneedling	□ Wrinkles/Fine Lines	□ Hair Loss
□ Chemical Peels	□ Skin Care	□ Red/Brown Spots	□ Thread Lift	□ PRP

□ Have you ever had a complication with a cosmetic procedure? _____

Leg Vein Screen (Check if you have had any of the following):

□ Cramping/Night Cramps	□ Leg Pain/Aching	□ Leg Itching	□ Leg Swelling	□ Leg Rashes

Vaccinations:

□ I have had a flu shot this flu season □ I have had a pneumonia shot

Current Medications, Vitamins, and Supplements: □ **See List**

_____ _____ _____

_____ _____ _____

_____ _____ _____

□ I am **ALLERGIC** to these medications: _____ □ **NO ALLERGIES**

Smoking Status: □ Never □ Former □ Current: # of packs per day: _____

Alcohol Status: How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? □ 1 or less □ 2 or more

Occupation: _____

Reason for Today's Visit: _____