SCDRI

Name: _____ Date of Birth: _____

Patient Home Phone**:** _____ Patient Cell Phone: _____

Race: □ White □Hispanic □Black or African American □Other race
Ethnicity: □Hispanic or Latin □Non-Hispanic □Other
Language: □English □Spanish □Portuguese □Russian □_____
Gender: □Female □Male □_____

Email address: _____

Emergency Contact: _____Relationship: _____Phone: _____

Primary care Physician:_____

Pharmacy: _____ Pharmacy Phone Number:_____
Pharmacy Street Name: _____ Pharmacy City:_____

Financial Consent
Surgical and Cosmetic Dermatology of Rhode Island has permission to bill my Insurance Company (s) for fees associated with my treatment. I will be responsible for paying my deductible, co-pay(s) or co-insurance. I understand I am responsible for contacting my insurance company for eligibility, financial responsibility and if the service is covered. (If you want the codes to give your insurance company, please contact our office).
Patient Signature: _____ Date: _____/_____/_____

Photography Consent
I consent for medical photographs to be made of me (or person for whom I am the Power of Attorney for). I understand that the information may be used in my medical record.
Patient Signature: _____ Date: _____/_____/_____

Pharmacy History Consent
I consent for my Pharmaceutical history to be obtained if necessary. This will insure I am not prescribed any duplicate or similar prescriptions.
Patient Signature: _____ Date: _____/_____/_____

Privacy Practices Acknowledgement
A copy of the Notice of Privacy Practices is available at the check-in counter. I have been offered the Notice of Privacy
Patient Signature: _____ Date: _____/_____/_____

No Surprises Act
A copy of the No Surprises Act is available at the check-in counter. I have been offered the No Surprises Act
Patient Signature: _____ Date: _____/_____/_____

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REVIEW OF SYMPTOMS

Overall, how do you feel physically? □Excellent □Good □Fair

Heart □Angina □Defibrillator □Pacemaker □Heart Failure □Stents □Heart Murmur
□Heart Attack(s) □High Blood Pressure □other _____

Psychiatric □Anxiety □Depression □Frequent fainting spells □other _____

Muscular/Skeletal □Arthritis □Hip replacement □Knee replacement

Pulmonary □Emphysema □Asthma □Shortness of breath □Chronic cough □Other _____

Hematologic □Bleeding problems □Anemia □Bruises easily □Other _____

Cancer □Breast □Lung □Lymphoma □Other _____

Healing Problems □Keloids □Skin discolorations □Other _____

Infectious Disease □High risk for AIDS □Hepatitis □Tuberculosis □HIV+ □Other

Genitourinary □Prostate issues □Transplant □Kidney disease □Dialysis □Other

Liver □Liver disease □Cirrhosis □Hepatitis

Gastrointestinal □Irritable bowel □Ulcers □Reflux □Other _____

Neurological □Seizures □Stroke(s) □TIA □Frequent headaches □Migraines

Endocrine □Thyroid disease □Diabetes □Other_____

Eyes □Decreased vision □Eye pain □Glaucoma □Constant tearing

Ears □Decreased hearing □Hearing aides

Nose □Draining allergies □Restricted breathing

Surgical History: _____

Any other Past Medical History: _____

Allergies Are you allergic to any medications? □No □Yes _____

Do you need to take antibiotics prior to dental work? □No □Yes, reason _____

Medications Do you take: □Aspirin _____mg's daily □Coumadin/Warfarin _____mg's daily □Plavix _____mg's daily
Please list any other medications/supplements/vitamins that you are currently taking:
_____

_____

_____

Social History Do you drink alcohol □No □Yes if yes, Frequency □Daily □Weekend □Social occasions
Do you smoke? □Never □Former
□Yes packs per day=_____ Do you want to quit? □No □Yes

Family History Has any genetic family member had skin cancer? □No □Unknown
□Yes: Relationship_____ □Alive/age_____ □Deceased

Chief Complaint □Skin cancer □Other issue _____

History of present illness

How long have you had the above chief complaint?_____

What are the symptoms? □none □Bleeding □Itching □Scabbing □Pain □Other _____

Has it previously been treated with: □none □Cryotherapy (liquid Nitrogen) □Burned/Scraped □Radiation

Dermatologic History

Have you ever had radiation to the skin? □yes □no

Rate your lifetime sun exposure: □always burn/never tan □burn then tan □always tan

Have you had skin cancer before? □no □yes

FOR STAFF USE ONLY

Location: _____ Location: _____

DX: _____ DX: _____

Size: _____x _____ cm Size: _____x _____ cm

Description: _____ Description: _____

Closure:_____ Closure:_____