SCDRI

Name____ Date of Birth: ___/_____/____

Address: ________________________________City_________________________State__________Zip_________

Phone number: Home__________________________________Cell___________________ Work_________________

Email address: ____

Primary Care Physician: ____Phone: __________________________

Local Pharmacy: __________________________Street _____________ City_____________ Phone_____________

Emergency Contact:
Name: _______________________ Relation:________________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 □________

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) and/or co-insurance. I understand it is my responsibility to get a referral from my primary care physician if my insurance requires it. I understand if I do not give the correct insurance information to this office I will be billed for the services.
Patient signature: ______________________________________ Date: ________________________

Photography Consent
I consent for medical photographs to be taken for the use of documentation in my medical record.
Patient signature: _______________________________________ Date: ________________________

Pharmaceutical History Consent
I consent for my pharmaceutical history to be obtained.
Patient signature: _______________________________________ Date: ________________________

Privacy Practices Acknowledgement
A copy of Privacy Practices is at the check in window. I have been offered the Notice of Privacy Practices.
Patient signature: _______________________________________ Date: ________________________

No Surprises Act
A copy of the No Surprises Act is at the check in window. I have been offered the Notice of the No Suprises Act.
Patient signature: _______________________________________ Date: ________________________

Appointments:
I understand that if I do not show to a scheduled appointment, I will have to pay $75. If I do not show to a second appointment I will be discharged from the practice.
Patient signature: ____ Date: ________________________

SCDRI

Name: ____ Date of Birth: __________________

HISTORY OF PRESENT ILLNESS

What are you here to discuss? ____

What are the symptoms? □None □Bleeding □Itching □Scabbing □Pain □Other _________

Have you had treatment before for this? □No □Yes (what kind) ________________________

REVIEW OF SYSTEMS

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

Heart □Angina □Defibrillator □Pacemaker □Heart failure □Stents □Heart murmur □Heart attack □High blood pressure □other ____

Psychiatric □Anxiety □Depression □Frequent fainting spells □other______________________

Muscular/Skeletal □Arthritis □Joint replacement □other ____________

Pulmonary □Emphysema □Asthma □Shortness of breath □Chronic cough □other____________

Hematologic □Anemia □Bleeding problems □Bruises easily □other ___________________________

Cancer □Breast □Lung □Lymphoma □Prostate □other ______________________________

Healing problems □Keloids □other ____

Infections Disease □High risk for AIDS □Hepatitis □Tuberculosis □HIV+ □other ____________

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

Liver □Liver disease □Cirrhosis □Hepatitis ___ □other_________________________

Gastrointestinal □IBS □Ulcers □Reflux □other ______________________________

Neurological □Seizures □Stroke □TIA □other ____________________________________

Endocrine □Thyroid Disease □Diabetes type ___ □other __________________________

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

Ears □Decrease hearing □Hearing aides

Nose □Draining allergies □Restricted breathing

Skin □Abnormal moles □Bleeding lesions □Skin lesions □Skin cancers □Breast lumps □Rashes □Eruptions □Itching □Sweating □Darkened skin/pigmentation □ Lightened skin/loss of pigmentation

SURGICAL HISTORY: ____

ALLERGIES:____

MEDICATIONS/SUPPLEMENTS: □see attached

____

____

SOCIAL HISTORY:

Smoking □Yes □no □former

Alcohol □No □Yes □Daily □Weekend □Social occasions

FAMILY HISTORY:

Has any genetic family member had skin cancer? □No □Unknown □Yes ________

Do you have an advanced care plan? □Yes □no

Do you have a health surrogate? □Yes □no

Female patients: Are you currently pregnant? □No □Yes # of weeks____