SCDRI (Under 18 years old)

Patient Name_____ Date of Birth: ___/_____/____

Parent/Guardian Names _____
Is there a divorce documents that states you are the sole medical decision-making parent/guardian?
Yes_____(initials) No _____(initials). If yes, please bring that document to the appointment.

Address: _____City_____State_____Zip_____

Parent Phone number: Home_____Cell_____ Work_____

Parent 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: _____

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____