PEDIATRIC DERMATOLOGY OF ORANGE COUNTY

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REGISTRATION FORM

PATIENT INFORMATION					
Patient's name: Last		First		Nickname:	
Birth date: / /	Age:	Sex: ❑ M ❑ F	Home phone #: ( )		Parent cell phone #: ( )
Street address:		City:	State:		ZIP Code:
Patient lives with : ❑ Both parents ❑ Mother ❑Father ❑ Other:					
Email: *(For appointment confirmation only. This will not be shared or used for other purposes.)*					
Referred to clinic by (please check one box):		❑ Dr.		❑ Insurance Plan	
❑ Family	❑ Friend	❑ Online search	❑ Other		
Other family members seen here:					
Primary Care Physician:					
Emergency Contact Information					
Name:		Phone:		Relationship:	

INSURANCE INFORMATION *(Please fill out completely)*				
Please give your insurance card and photo ID to the receptionist.				
Primary insurance:		Subscriber's name:		Birth date: / /
Patient's relationship to subscriber:	❑ Child	❑ Self	❑ Spouse	❑ Other ___________________________
Secondary insurance (if applicable):		Subscriber's name:		Birth date: / /
Patient's relationship to subscriber:	❑ Child	❑ Self	❑ Spouse	❑ Other ___________________________

PRESCRIPTION COVERAGE *(If separate from Primary Insurance)*				
Primary Insurance:		Subscriber's name:		Birth date: / /
Rx BIN:	Rx PCN:	Rx GRP:	Issuer:	Rx ID

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Completing this form prior to your visit will help to make the most of your time with us!

Patient Name: ______________________________________

DOB: ______________________

Primary Care Physician:
Name ____
Did this doctor refer you to us? YES / NO

If a different physician referred you, please list here:
Name ____

Pharmacy:
Name ____
Street & City ____

MEDICAL HISTORY: Do you have (or have you had) any of the following?
☐ arthritis
☐ asthma
☐ cancer: type _________________
☐ leukemia
☐ lymphoma
☐ transplant: type _______________
☐ depression
☐ hyperthyroidism
☐ hypothyroidism
☐ seizures
☐ diabetes
☐ other: _______________________

PAST SURGERIES:
____
____

SKIN HISTORY: Do you have a history of the following?
☐ acne
☐ skin cancer: melanoma / basal cell / squamous cell
☐ abnormal moles
☐ blistering sunburns
☐ dry skin
☐ eczema
☐ psoriasis

Do you wear sunscreen? YES / NO

Do you have a family history of melanoma? YES / NO
If yes, which family member(s)?
____

FAMILY HISTORY:
☐ skin cancer: melanoma / basal cell / squamous cell
☐ abnormal moles
☐ eczema
☐ asthma
☐ diabetes
☐ high cholesterol
☐ Other____

DO YOU TAKE ANY MEDICATIONS? YES / NO
If yes, please list:
____
____
____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS?
YES / NO If yes, please list:
____
____

REVIEW OF SYSTEMS: (Check all that apply)

☐ allergy to adhesive
☐ allergy to topical antibiotic ointments
☐ allergy to lidocaine
☐ allergy to latex
☐ pregnancy or planning a pregnancy
☐ problems with scarring (hypertrophic or keloid)
☐ problems with bleeding
☐ immunosuppression
☐ fever or chills
☐ sore throat
☐ cough
☐ night sweats
☐ thyroid problems
☐ unintentional weight loss / weight gain
☐ heat intolerance
☐ cold intolerance
☐ diarrhea
☐ constipation
☐ abdominal pain
☐ chest pain
☐ changing mole
☐ rash
☐ muscle weakness
☐ hay fever
☐ wheezing
☐ seizures
☐ anxiety
☐ muscle aches
☐ joint aches
☐ bloody stool
☐ headaches
☐ blurry vision
☐ depression

Other: ____