Today's Date: **Patient Information**

Name:

Date of Birth:

Address:

Email:

Preferred Phone #:

We offer helpful information regarding your care by regular text messaging and email. Although we use the most advanced software to ensure that transmitted messages are secure, there is some level of risk that information in a regular text message or email could be read by someone besides you.

Is it Ok to leave a detailed Voice message? ☐ **YES** ☐ **NO**
Would you like to opt in to Email notifications? ☐ **YES** ☐ **NO**
Would you like to opt in to Text notifications? ☐ **YES** ☐ **NO**

Emergency Contact Information

First	Last	Relationship	Contact #

Can we discuss your Health Care Information with the person listed above? ☐ **YES** ☐ **NO**

Please list any medical providers you would like to authorize to have access to your medical records. These records will only be released upon your verbal request. You may revoke this authorization in writing at any time. By completing this section, you are authorizing Arsenault Dermatology to release your medical record (including laboratory test results) to the Provider(s) listed.

Primary Care Physician Name: _____ City: _____

Were you referred to our office by a physician? Please circle: Yes No

If yes, Referring Physician Name: _____ City: _____

Please sign below acknowledging that the above information is correct:

_____

Signature

Patient Name: Date of Birth:

Social History

Smoking Status (please circle one) Current smoker Former Smoker Never Smoked

Alcohol **Intake *(please answer the following):***

Men: How many times in the past year, have you had 5 or more drinks in a day? _____

Women: How many times in the past year, have you had 4 or more drinks in a day? _____

Please list all current medications with all the requested information *(If you do not take any medications please write NONE)*

	Medication Name	Strength	How many times a day?
1.			
2.			
3.			
4.			
5.			

Allergies

Please list all allergies to medications and the reaction you have. *(if you do not have any allergies to drugs, please write NONE)*

Medication Name	Reaction to medication

Please answer the following if you are ***65 years of age or older***

Do you have any of the following? If you do not, please circle none.
Please furnish a copy of legal documents to Arsenault Dermatology, if necessary.

None Living Will A Health Care Proxy

Health Care Proxy name and contact number: _____

Which statement best reflects your wishes on advanced care recommendations?
Please select one of the following:

- **Full Code:** I wish to have full cardiopulmonary resuscitation efforts to be made.
- **Do Not Intubate:** I do NOT wish to have a breathing tube, even if it is required for life saving measures.
- **Do Not Resuscitate:** In the event that my heart was to stop, I do NOT wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is required for life saving measure.