Today's Date: **Patient Information**

Name:

Date of Birth: Gender:

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

Family Information:

Primary Parent/Legal Guardian (*Primary Insurance Holder*)

Full name of Policy Holder (as it appears on insurance card): _____

Gender: Male Female Relationship to Patient: _____ Phone#: _____

Date of Birth: _____/_____/_____

Other Parent/Legal Guardian:

Full Name: _____ Gender: Male Female

Relationship to Patient: _____ Phone#: _____

Marital Status: Married Divorced Other: _____ *with whom does the patient reside? _____

* If all guardians do not reside at the address listed above, please provide a secondary address for statements

Address: _____ City: _____ State: ____ Zip Code: _____

Email Address: _____

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.

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

Today's Date:

Patients Name **Date of Birth:**

Medications

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

	Medication	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

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? _____

Have you received any of the below vaccinations? (please check all that apply)

One - **Tdap** Vaccine _____ ***One*** **- TD** Vaccine _____

One - **Meningococcal** Vaccine _____

Three - **HPV** Vaccinations _____