Arsenault DERMATOLOGY

Name: _____

Date of Birth: _____

Today's Date: _____

Clinical Intake

Past Medical History

Yes	No	
☐	☐	Autoimmune disease
☐	☐	Bowel / stomach disease
☐	☐	Internal cancer
☐	☐	Genital disease
☐	☐	Heart attack
☐	☐	Infectious disease
☐	☐	Kidney disease
☐	☐	Liver disease
☐	☐	Lung disease
☐	☐	Seizures
☐	☐	Do you have a stent?
☐	☐	Stroke

If yes, provide details:

Review of Systems

Yes	No	
☐	☐	Problems with your immune system
☐	☐	Do you take medications that lower your immune system?
☐	☐	Do you faint with procedures?
☐	☐	Blood thinners
☐	☐	History of MRSA
☐	☐	HIV / AIDS / Hepatitis C
☐	☐	Premedicate prior to a procedure
☐	☐	Pregnant or trying to become pregnant
☐	☐	Breastfeeding

Skin History

Yes	No	
☐	☐	Non-Melanoma Skin Cancer
☐	☐	Melanoma (before becoming our patient)

if yes, what year? _____

Lymph nodes removed? _____

Current Medications

_____

_____

_____

_____

_____

Allergies

Please list all allergies to medications and the reaction you have (if none write **NONE**):

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Required CMS Questions

All patients

Check all that apply to you:

- ☐ **Never smoked**
- ☐ **Former smoker**
- ☐ **Current smoker**

All patients **17 years of age or younger**

Have you received any of these vaccinations?

(select all that apply)

- ☐ **One (1) Meningococcal Vaccine**
- ☐ **One (1) TD Vaccine**
- ☐ **One (1) Tdap Vaccine**
- ☐ **Three (3) HPV Vaccinations**

All patients **65 years of age or older**

Check all that apply to you:

- ☐ **Living will**
- ☐ **Health care proxy**
- ☐ **None**

Which statement best reflects your wishes on advance care recommendations? **(select one)**

- ☐ **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 living saving measures.*

Health care proxy name & contact number:

Provide copies of legal documents to our team.

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Patient Registration

Demographics

Name:

Date of Birth:

Address:

Email:

Preferred Phone #:

Communications

We protect your privacy by using advanced software. **You will receive the best service by allowing text messages.** We **NEVER** sell patient data to 3rd party marketing companies.

We have permission to:	Yes	No
Leave a voicemail	☐	☐
Send email notifications	☐	☐
Send text reminders and results	☐	☐

Note:
HIPAA requires us to inform you that all patients accept responsibility associated with protecting their own voice, email, and text notifications.

Minor Patients Only

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

Date of Birth: ___/___/___ Gender: **Male / Female** Phone Number: _____

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

I acknowledge all of the above information is correct:

_____
Patient / Legal Guardian Signature