Arsenault DERMATOLOGY

Today's Date: _____ **Demographics (1 of 2)**

Patient Information:

First	M.I.	Last	Date of Birth	**Circle One:** Male/Female

Address	City	State	Zip Code

Email Address

Contact Information:

		MAY WE LEAVE DETAILED MESSAGES (i.e. Appointments, billing, results, etc.)?		
Home #: ( )		YES	NO	N/A
Mobile #: ( )		YES	NO	N/A
Work #: ( )		YES	NO	N/A
Would you like to receive Text Messages?		YES	NO	N/A

Emergency Contact Information:

Can we discuss your health care information with the below person? **YES** **NO**

First	M.I.	Last	Relationship	Contact Telephone #

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: _____ Phone #: _____

Address: _____ Fax #: _____

Other Physician: _____ Phone #: _____

Address: _____ Fax #: _____

Where you referred to our office by a physician? YES / NO

If yes, Referring Physician: _____ Phone #: _____

Address: _____ Fax #: _____

Arsenault DERMATOLOGY

Demographics (2 of 2)

Today's Date: _____

Patient's Name: _____ **DOB:** _____

Which provider are you seeing today?

Circle One:

Emily F. Arsenault, MD | Meredith M. Miller, PA-C | Kristin L. Jochum, PA-C
Laura E. Marano, PA-C | Melissa M. Beachy, PA-C | Conor P. Dolehide, MD | Christina M. Troiano, PA-C

Affordable Healthcare Act Questionnaire:

Race (circle only one)

I choose not to specify | American Indian/Alaskan Native | Asian | White/Caucasian
Native Hawaiian/Other Pacific Island | Black/African American | Other: _____

Ethnicity (circle only one)

I choose not to specify | Not Hispanic or Latino | Hispanic or Latino

Preferred Language (circle only one)

I choose not to specify | English | Spanish | American Sign Language | Other: _____

Do you have any of the following? (circle all that apply)
****If yes, please furnish copy of legal documents to Arsenault Dermatology, if necessary.**

Power of Attorney (Surrogate Decision Maker) | Living Will (Advance Care Plan) | None

Privacy Acknowledgment:

_____ **Initials** **We are required to protect your privacy**
Our Notice of Privacy Policy (NPP) details your rights as a patient and how we may use and/or disclose your protected health information. Our NPP is available on our website and/or is furnished.

_____ **Initials** **We request all patients present a valid photo ID at each visit, unless we have it on file.**
Your cooperation with HIPAA requirement is designed to protect your identity from misuse.

_____ **Initials** **Patients may revoke or change any provided authorizations at any time.**
Please refer to our NPP for more details.

Arsenault DERMATOLOGY

Today's Date: _____ **Review of Systems (1 of 2)**

Patient's Name: _____ **DOB:** _____

Medical History:

Do you currently and/or have had past medical problems with the following? **Please check - "Yes" or "No"**

Weight Loss		
Skin		
Have you been diagnosed with Melanoma?		
…If yes, Did you have an X-Ray, Catscan, MRI or Petscan?		
Eyes		
Ears / Nose / Throat / Mouth		
Heart Disease / Heart Failure / Coronary Artery Disease (CAD) / High Blood Pressure / High Cholesterol		
…If yes, do you have a specialist?		
Lung Disease / Chronic Obstructive Pulmonary Disease (COPD)		
…If yes, do you have a specialist?		
Stomach / Bowel		
Kidneys		
Arthritis / Muscles / Joints		
Headaches / Dizziness / Seizures		
Psychological Disorders		
Thyroid		
Diabetes		
……If yes, do you see a specialist?		
Blood / Bleeding Disorders		
Did you receive the flu vaccine before this past flu season?		
Have you ever received the pneumonia vaccine?		
Other, if not listed		
What is the date of your last visit with your Primary Care Physician?	**Date:** ____/____/____	
Females: Are you pregnant?		

Past Surgeries/Hospitalizations (If None, Please write NONE)

Surgeries / Hospitalizations	Date	Notes

Arsenault DERMATOLOGY

Review of Systems (2 of 2)

Today's Date: _____

Patient's Name: _____ **DOB:** _____

Social History:

Do You Live Alone? **Yes** **No**

Are you Exposed to Chemicals at Work? **Yes** **No**

…If Yes, Please List Chemicals you are Exposed to: _____

_____

What is Your Occupation? _____

What are Your Hobbies? _____

Family History: Please check conditions that have occurred in your immediate family:

Condition	N/A or Unknown	Parent	Sibling / Child
Skin Cancer			
Eczema			
Psoriasis			
Diabetes			
Autoimmune Disease			

Smoking Status: (circle only one)

Current every day tobacco smoker

Current sometimes tobacco smoker

Never been a tobacco smoker

Current smokeless tobacco user

Former Tobacco Smoker: When did you start? _____

When did you stop? _____

Alcohol Consumption:

How many times in the past year have you had 4 or more drinks in a day? **(circle only one)**

None

Less than twice per year

More than twice per year

Arsenault DERMATOLOGY

Allergies & Medications

Today's Date: _____

Patient's Name: _____ **DOB:** _____

Pharmacy Information:

Pharmacy Name: _____ Phone #: _____

Address: _____ Fax #: _____

Allergies:

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

Current Medications:

Medication Name	Strength	How many times a day?