Alaska Center for Dermatology, P. C.
3841 Piper Street | Suite T4-020 | Anchorage, AK 99508 | telephone 907.646.8500 | fax 907.646.9760

Dermatology Intake Form – Est

Patient Name_____**Date of Birth**_____

Occupation_____ **Preferred Pharmacy & Location**_____

Medication/Allergies

Do you take any prescription or non-prescription medication? ☐ Yes ☐ No

If Yes, please list:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Please list all allergies to medication: ☐ No Known Drug Allergies

1. _____ 2. _____ 3. _____

Skin	**Yes**	**No**	
Do you have a personal history of melanoma?	☐	☐	
Have you ever had skin cancer?	☐	☐	If Yes, what type? _____
Has anyone in your family had skin cancer?	☐	☐	If Yes, what type? _____
Do you have a history of any specific skin diseases?	☐	☐	If Yes, please list: _____
Do you have problems with healing?	☐	☐	
Do you develop keloids after surgery?	☐	☐	
Do you bleed easily?	☐	☐	

Do you develop skin rashes in reaction to ☐ Medications? ☐ Food? ☐ Environment?

If Yes, please explain: _____

Medical History

Do you have now or have you ever had:

☐ Asthma ☐ COPD ☐ Tuberculosis ☐ High blood pressure ☐ Heart attack ☐ Irregular heartbeat ☐ Stroke
☐ Diabetes ☐ Arthritis ☐ Hyperthyroid ☐ Hypothyroid ☐ Artificial Joints ☐ Hepatitis B/C ☐ HIV/AIDS

History of Cancer? ☐ Yes ☐ No If Yes, what type and where: _____

If Yes, what was your treatment:_____

Do you have a pacemaker? ☐ Yes ☐ No If Yes, does it have a defibrillator? _____

List any surgeries you have had in the last six months: _____

Social History

Smoking Status:

☐ Never smoked
☐ Current every day smoker
☐ Current some day smoker
☐ Former Smoker

Women:

Are you pregnant or trying to conceive? ☐ Yes ☐ No

If you are currently pregnant, what is your due date? _____

Are you currently breastfeeding? ☐ Yes ☐ No

Cultural Information

Race: ☐ Caucasian or European American ☐ African American ☐ Asian or Asian American
☐ Native Alaskan or Native American ☐ Native Hawaiian or Other Pacific Islander ☐ Prefer not to answer

Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Prefer not to answer

Preferred Language: _____

Signature _____**Date**_____

(Patient, Or Guardian if Minor)

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Patient Registration Form

Please print all information clearly.

Patient

Name _____ Date of Birth _____/_____/_____
first middle initial last

Nickname _____ SS# _____/_____/_____ Sex: ☐ Male ☐ Female

Mailing Address: _____
city state zip

Primary Phone: _____
(please choose ONE of the following)
- ☐ OK to call, leaving detailed message if no answer
- ☐ OK to call, leaving message with call-back number only if no answer
- ☐ OK to call, but leave no message if no answer

Work Phone: _____
(please choose ONE of the following)
- ☐ OK to call, leaving detailed message if no answer
- ☐ OK to call, leaving message with call-back number only if no answer
- ☐ OK to call, but leave no message if no answer

Other Phone: _____
(please choose ONE of the following)
- ☐ OK to call, leaving detailed message if no answer
- ☐ OK to call, leaving message with call-back number only if no answer
- ☐ OK to call, but leave no message if no answer

Who should we contact in the event of an emergency?
Name _____
Phone(s) _____
Relationship to Patient _____

May we discuss your condition with a member of your household? ☐ Yes ☐ No

If so, with whom? _____ Relationship to Patient _____

Were you referred to us by another doctor? ☐ Yes ☐ No If so, by whom? _____

Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Prefer not to answer

Race: ☐ Caucasian or European American ☐ African American ☐ Asian or Asian American
☐ Native Alaskan or Native American ☐ Native Hawaiian or Other Pacific Islander ☐ Prefer not to answer

Preferred Language: _____

Insurance *(Please present insurance card(s) and a photo ID to receptionist for scanning.)*

Do you have **Primary** Insurance? ☐ Yes ☐ No If Yes: Insurance Name _____

Policy Holder's Name _____ Date of Birth _____ Relationship to Patient _____

Do you have **Secondary** Insurance? ☐ Yes ☐ No If Yes: Insurance Name _____

Policy Holder's Name _____ Date of Birth _____ Relationship to Patient _____

Please complete the following if the patient is a minor or disabled.

(The person accompanying the patient today is considered the "Responsible Party".)

Responsible Party Name _____ Date of Birth ___/____/_____ SS# _____/_____/_____

Mailing Address: _____
city state zip

Assignment and Release

I authorize the release of any information to my referring physician.
I hereby authorize Alaska Center for Dermatology to furnish my information to insurance carriers upon their written request and hereby assign to Alaska Center for Dermatology all payments for medical services rendered to the above patient.

_____ _____

Patient Signature (or Responsible Party) **Date**