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Coastal Dermatology
and cosmetic center

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Patient Registration Form

Welcome! Thank you for choosing Coastal Dermatology & Cosmetic Center.
Please completely fill out this form to ensure the fastest and best healthcare service.

Patient Name: ______________________________ Birthdate: _____/_____/______ Preferred Language: ________________

Sex: M_______ F_______ Gender Identity: M_______ F_______ Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widow

Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Decline to answer [ ] Other_______________

Race: [ ]Caucasian [ ]Hispanic or Latino [ ]African American [ ]American Indian [ ]Alaskan Native [ ]Asian [ ]Decline to answer [ ]Other

Home Address: ________________________________City: ________________ State: ______ Zip: _________

Telephone: Home: ________________ Cell:________________ Email: ___________________________

Do you give the office permission to call and/or leave messages on your phone numbers listed above: [ ] Yes [ ] No

Employer: ________________________________ Occupation: ____________________________

Primary Physician: __________________________ Phone #: _______________Fax #: ________________

Referring Physician: _________________________ Phone #: _______________Fax #: ________________

Pharmacy: ______________________________ Pharmacy Phone: ____________________________

Pharmacy Address: _________________________ City: ____________________ State: _____ Zip: ________

Emergency Contact: __________________________ Relationship: ______________Phone #: ____________

Insurance Information:

Primary Insurance: ___________________________ Secondary Insurance: ___________________________

Subscriber's Name: ________________ DOB:________ Subscriber's Name: ________________ DOB:_________

By signing below, I hereby authorize Coastal Dermatology & Cosmetic Center to disclose my Protected Health Information to the following family members, friends or representatives.

Name: ______________________________ Relationship: ________________________________

Name: ______________________________ Relationship: ________________________________

Patient/Legal Guardian Signature: ______________________________ Date: __________________

I consent to treatment necessary for care of the above named patient. I authorized the release of all medical records to the referring family physician and to my insurance company. If applicable, I allow fax transmittal of my medical records. If necessary, I acknowledge full financial responsibility for services rendered by Coastal Dermatology & Cosmetic Center, Inc. If my insurance does not pay for all or part of the services rendered to me by physician I understand that I am fully responsible for payment of all services. I understand that full payment/co-payment are due at the time of service unless other definite financial arrangements have been made prior to treatment. I future authorize and request that insurance payments be made directly to Coastal Dermatology & Cosmetic Center, Inc. should they elect to receive such payments. I have read and fully understand the above consent of treatment, financial responsibility and insurance authorization.

Patient/Legal Guardian Signature: ____________________________________ Date: ____________

I consent to give my permission for photography to be used for comparison of the treatment results and medical records.

Patient/Legal Guardian Signature: ____________________________________ Date: ____________

What is the primary reason for your visit today?

☐ Full Skin Exam ☐ Rash ☐ Changing Mole ☐ Acne ☐ Psoriasis

☐ Warts ☐ Cosmetic Consult ☐ Other________________________

Current medications:

Medication	Dose	How often	Medication	Dose	How often

Do you give consent for Coastal Dermatology to import your medication list from your pharmacy? ☐ ***Yes*** ☐ ***No***

Allergies: ____ ☐ No known allergies

Past Medical History: (please circle all that apply)

None, Anxiety, Arthritis
Artificial joints, Asthma, Atrial fibrillation
COPD, BPH (Benign Prostate Hyperplasia), Bone Marrow Transplantation
Cancer: Type______________, Coronary Artery Disease, Depression
Diabetes, End Stage Renal Disease, GERD (Acid reflux)
Hearing Loss, Hepatitis, Hypertension
HIV/AIDS, Hypercholesterolemia, Seizures
Hyperthyroidism, Hypothyroidism, Stroke
Leukemia, Lymphoma, Other: ____________________

Past Surgeries: **(please circle all that apply)**

None, Appendix Removed, Bladder Removed
Gallbladder Removed, Prostate Removed, Prostate Biopsy
Testicles Removed, Skin Cancer Surgery, Spleen Removed
Pancreas Removed, Coronary Artery Bypass, Valve Replacement
Lumpectomy (Right/Left/Both), Breast Biopsy (Right/Left/Both), Mastectomy (Right/Left/Both)
Kidney Removed (Right/ Left), Kidney Stone Removal, Organ Transplant: __________
Knee Replacement (Right/ Left/ Both), Hip Replacement (Right/ Left/ Both)
Hysterectomy: Fibroids/ Uterine Cancer/ Other, Ovaries Removed: Endometriosis/ Cyst/ Cancer/ Other
Colectomy: Colon Cancer Resection/ IBD/ Other, Other: _____________________________________

Skin Disease History: **(please circle all that apply)**

None, Acne, Actinic Keratoses, Blistering Sunburns
Dry Skin, Eczema, Hay Fever/Allergies, Psoriasis
Precancerous Moles, Basal Cell Skin Cancer, Squamous Cell Skin Cancer, Melanoma
Flaking or Itchy Scalp, Other: ___________________

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Family History:

□ Melanoma. Relatives: ____

□ Basal Cell Carcinoma. Relatives: ____

□ Squamous Cell Carcinoma. Relatives: ____

□ Hay Fever/Allergies. Relatives: ____

□ Precancerous Moles. Relatives: ____

□ Psoriasis. Relatives: ____

□ Other (please specify) ____

Please check YES or NO to each of the following as they apply to you at TODAY'S VISIT

SYMPTOM	YES	NO	SYMPTOM	YES	NO
Problems with Bleeding			Neck stiffness		
Problems with Healing/ Scarring			Headaches		
Immunosuppression			Joint aches		
Rash			Wheezing		
Hay fever			Allergy to topical Antibiotic		
Chest pain			MRSA		
Fever or chills			On Blood Thinners		
Night sweats			Defibrillator		
Unintentional weight loss			Pacemaker		
Thyroid problems			Artificial Heart Valve		
Sore throat			Artificial Joint within past 2 years		
Blurry vision			Premedication prior to procedures		
Nausea/ Vomiting/ Diarrhea			Pregnancy or planning pregnancy		
Abdominal pain			Allergy to Adhesive		
Bloody stool or bloody urine			Allergy to Lidocaine		
Muscle weakness			Allergy to Epinephrine		

Do you have any of the following symptoms today? □ None

□ Flu-Like symptoms □ Fever □ Cough □Fatigue □Body aches □ Shortness of breath

In the two weeks, have you traveled domestically or internationally? □ No □ Yes

If yes, where: ______________________________

Tobacco:

□ Never Smoker □ Current Smoker □ Former Smoker

Alcohol:

□ No Alcohol □ Less than 1 drink/day □ 1-2 drinks/ day □ 3 or more drinks/day

Immunizations:

Did you receive the Influenza vaccine during the last flu season? □ YES □ NO

Have you received the COVID-19 Vaccine? □ YES □ NO

Certification of patient information:

I certify that all information provided on this date to Coastal Dermatology & Cosmetic Center is correct.

Signature: ______________________________________**Date**: ____________________