**MARTIN DERMATOLOGY**

**Please provide insurance card(S) & photo id or drivers license**

Today’s Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** SS #:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT INFORMATION:**

Patient’s Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(First Name) (M.I.) (Last Name)

I preferred to be addressed as / my nickname is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: 🞐 M 🞐 F

Florida Address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Street Address) (City/State) (Zip Code)

“Up North” Address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Street Address) (City/State) (Zip Code)

Home Phone: (\_\_\_\_\_) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Cell Phone: (\_\_\_\_\_) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Email: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRIMARY CARE/REFERRING PHYSICIAN INFORMATION:**

Did a Physician Refer You?  NO  YES Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_?

|  |  |  |
| --- | --- | --- |
| **How did you find us? Were you referred by**: |  |  |
| Physician  Family or friend *(name):*  Other *(please specify)* | Insurance Book\_\_\_\_\_\_  Prior Patient\_\_\_\_\_\_\_\_\_  Saw our Billboard\_\_\_\_ | Internet \_\_\_\_\_\_\_\_  Newspaper Ad\_\_\_  Mailing \_\_\_\_\_\_\_\_\_ |

**FOR MINORS ONLY: PARENT OR LEGAL GUARDIAN INFORMATION –**

Parent or Legal Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DEMOGRAPHICS:**

**1) Race:**   American Indian or Alaska Native  Asian  Black or African American  White

 Native Hawaiian  Other Pacific Islander  More than One Race  Refuse to Report

**2) Ethnicity:**  Hispanic or Latino  Not Hispanic  Unknown

**3) Preferred Language:** English Spanish Creole 🞎 other

**4) Preferred Notification Method:**  Postal Mail  Phone  Email

**5) Marital Status**:  M S  D W  Full time student

**EMERGENCY CONTACT INFORMATION**

In case of emergency, whom should we notify? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT EMPLOYMENT INFORMATION**

Patient’s Employer Name & Address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Employer’s Phone **(\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ** Full Time  Part Time  Retired  Not Employed

**INSURANCE COVERAGE: (we will need to make a copy of your cards – please provide your cards)**

Primary Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note**: Except for exceptional cases we will only file with your **primary** carrier. This policy **excludes** patients with Medicare.

**DISCLOSURES OF MEDICAL INFORMATION TO FAMILY MEMBERS AND FRIENDS**

I hereby give my permission to disclose personal medical information about my treatment to the following individuals:

 Same as Emergency Contact.

 I do **NOT** give permission to disclose personal medical information about my treatment to family members or friends.

 I authorize release of medical information to my primary care, referring doctors and consultants.

 I authorize you to send me practice related emails.

 These are the additional persons I give my permission to disclose information about my medical treatment:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MAY WE LEAVE PERSONAL MEDICAL INFORMATION ON YOUR ANSWERING MACHINE?**

 **YES**  **NO**

**PHARMACY INFORMATION (we transmit all prescriptions through the computer!)**

**Local** Pharmacy Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Phone #: (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mail Order** Pharmacy Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Phone #: (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ALL PATIENTS PLEASE READ AND INITIAL**

**Receipt of Notice of Privacy Practices Written Acknowledgment Form:**

I hereby acknowledge that I have been provided with an opportunity to review the privacy notice of health information practices of Martin Dermatology. \_\_\_\_\_\_\_\_\_\_ (initials)

**CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS, AND FINANCIAL POLICIES**

**I. Consent for treatment:** I authorize MARTIN DERMATOLOGY, its agents, and Sandy Martin MD to render treatment to me/my dependents for dermatological and medical/surgical care.

**II. Assignment of Benefits/Release of medical information:** I request that payment for authorized Medicare or other applicable private insurance benefits be paid directly to Martin Dermatology for services provided under their care. I also authorize Martin Dermatology to release necessary medical information to my insurance company, its agents, or any third party in order to determine payable benefits for the services rendered.

**III. Digital Photography:** I authorize the physicians/staff of Martin Dermatology to take digital photographs that relate to my care. Martin Dermatology will only disclose information relevant to my care to permitted persons and any and all physicians who care for me. The photographs may be used for teaching, academic and research purposes so long as my identity is concealed.

**IV. Financial Responsiblity:** I understand that I am ultimately responsible for any unpaid balance or non-covered service and am responsible for all costs of pursuing such balances if I fail to pay.

**V. Referrals/Authorization:** I understand that if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral at the time of service, no services will be rendered until I obtain a referral or sign a waiver of financial responsibility. Payment in full is required at the time of service.

**VI. Missed Appointments:** Our office requires 24 hour notice for cancellations. Failure to do so may result in a $50.00 fee.

**I have reviewed the statements above and understand my responsibilities and if I don’t understand my responsibilities, I agree that I can ask questions!**

Patient/Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR MEDICARE PATIENTS ONLY**

**Medicare Authorization:** I request that payment for Medicare Benefits be made on my behalf to MARTIN DERMATOLOGY for any services provided to me by its Providers. I authorize MARTIN DERMATOLOGY to release to the CMS and its agents any information needed to determine these benefits payable for related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare benefits apply.

**MEDICARE IS NOT ALWAYS THE PRIMARY INSURANCE. FEDERAL REGULATIONS REQUIRE THAT WE OBTAIN INFORMATION TO DETERMINE IF ANOTHER INSURER MAY BE PRIMARY TO MEDICARE:**

**1.** Do you or your spouse now work in a company which has 20 or more employees and have insurance at the job? \_\_\_Yes \_\_\_No

**2.** Are you covered by an HMO/PPO which makes Medicare secondary? \_\_\_Yes \_\_\_No

**3.** Is this illness/injury covered by the VA? \_\_\_\_Yes \_\_\_\_No

**4.** Is this illness /injury covered by Federal Black Lung or End Stage Renal Disease Program? \_\_\_\_Yes \_\_\_\_No

**5.** Is this illness/injury due to an automobile accident? \_\_\_\_Yes \_\_\_\_No

**6.** Is this illness/injury due to work related causes? \_\_\_\_Yes \_\_\_\_No

Patient Signature**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A copy of this signature will be used for release of information to your insurance companies and for assignment of benefits to Dr. Martin and Martin Dermatology.

**CO-PAYMENT AND DEDUCTIBLE ARE DUE WHEN SERVICES ARE RENDERED: NO EXCEPTIONS PLEASE, THANK YOU!**

**⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩⬩**

**CLINICAL INFORMATION FROM PATIENTS**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**YOUR MEDICATION ALLERGIES**

Medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT MEDICATIONS: PLEASE INCLUDE OVER-THE-COUNTER NON-PRESCRIPTION MEDICATIONS, VITAMINS, AND HERBAL DIETARY SUPPLEMENTS\*\***

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dosage | Frequency | Reason for Taking |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
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**MEDICAL HISTORY**

**REASON(S) FOR TODAY’S VISIT**

**1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **DO YOU HAVE A HISTORY OF HEPATITIS OR HIV?**  🞐 **YES**  🞐 **NO**  Are you nursing? 🞐 **YES 🞐 NO**  Are you pregnant? 🞐 **YES 🞐NO** If yes, due date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are you trying to get pregnant? 🞐 **YES 🞐 NO** |

**Do You Require Antibiotics prior to MINOR SKIN surgery? 🞐 YES 🞐 NO 🞐 I DON’T KNOW**

|  |  |  |  |
| --- | --- | --- | --- |
| □ ***Skin Cancer:***  ○ Melanoma; Date:\_\_\_\_\_\_\_\_\_\_\_\_\_  Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Which Dr has Records? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ○ Squamous Cell Carcinoma  ○ Basal Cell Carcinoma  ○ Actinic Keratosis (pre-skin cancer)  ○ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ ***Dermatological Disease:***  ○ Herpes/Cold Sores  ○ Psoriasis  ○ Eczema  ○ Acne  ○ Rosacea  ○ Blistering Disorder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ○ Healing problems: slow, keloid, bruising  ○ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***□ Immunological Disease:***  ○ Immune deficiency  ○ HIV/AIDS  ○ Lupus or Scleroderma  □ ***Hematology/Oncology:***  ○ Cancer; type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year\_\_\_\_\_\_\_  ○ Bleeding problems  □ ***Rheumatologic Disease:***  ○ Osteoarthritis  ○ Rheumatoid Arthritis  ○ Gout  □ ***Psychological/Emotional Disease:***  ○ Depression  ○ Obsessive-Compulsive  □ ***Gastrointestinal Disease:***  ***○*** Crohn’s Disease, Ulcerative Colitis  ***○*** Esophageal Reflux  ○ Peptic Ulcer  ○ Esophagitis  □ ***Orthopedic Disease:***  ○ artificial joint \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(area)  ○ When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | □ ***Cardiovascular Disease:***  ○ High Blood Pressure  ○ Heart problems;\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ○ Heart Attack; Date:\_\_\_\_\_\_\_\_\_\_\_\_  ○ **Pacemake**r  **○ Defibrillator**  ○ prostatic heart valve  ○ Irregular heartbeat  ○ High Cholesterol  □ ***Endocrine Disease:***  ○ Diabetes  ○ Hyperthyroid  ○ Hypothyroid  □ ***Neurological Disease:***  ○ Stroke/Aneurysm  ○ Seizure/Epilepsy  ○ Multiple Sclerosis (MS)  ○ Alzheimer’s  ○ Fainting  ***□ Liver Disease:***  ○ Hepatitis: type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ○ Jaundice  □ ***Lung Disease:***  ○ Asthma  ○ COPD  ○ Tuberculosis  □ ***Kidney Disease:***  ○ Poorly functioning kidneys  ○ Dialysis: Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***□ For Female Patients:***  ○ Are you pregnant/Planning Pregnancy  ○ Polycystic Ovary Disease  □ ***Other/Not Listed:***  ○ Transplant? Y N. What Type? \_\_\_\_\_\_\_\_\_  ○ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ○ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ○ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| lease add any others not listed)……. | | | |
| ***Conditions/Problems*** | **Family Medical History: Which Relatives??** | | |
| □□□□□□ Melanoma |  | | |
| □□ □ Non-Melanoma Skin Cancer |  | | |
| □□ □□ Blistering Disorder |  | | |
| □ Auto-Immune Disorder |  | | |
| □ □ Psoriasis□ |  | | |
| ia History/ Habits………………. Tanning/Sun Exposure | | | |
| □ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ Retired  □ Smoker:\_\_\_Packs/day □ Non-smoker □ Quit smoking in \_\_\_\_\_  □ Smokeless Tobacco: □ Y □ N  □ Alcohol use: □ Yes (drinks/week:\_\_\_\_\_\_\_\_\_\_\_) □ No  □ Recreational Drug use: □ No □ Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Sunscreen use: □ Regularly □ Rarely □ Never □ SPF \_\_\_\_\_\_  □ I have traveled outside the United States in the past  three months | | | Do you / Have you had:  □ Always burn, never tan  □ Usually burn, tan w/difficulty  □ Sometimes burns, usually tan  □ Rarely burn, tan easily  □ At least 1 Blistering sunburn  □ Utilize a tanning bed  How often?\_\_\_\_\_\_\_ x a month |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature Date