ASPIRE
DERMATOLOGY & AESTHETICS

PATIENT REGISTRATION FORM

Please verify that the following information is current, correct, and fill in anything that is left blank. Thank you.

Today's Date: _____

PATIENT INFORMATION

_____ _____ _____ Sex: ☐ Male ☐ Female ☐ Other
Name (Last) (First) (M.I)

_____ _____ _____ _____
Address City State Zip Code

_____
Email

Date of Birth: _____/_____/_____ Marital Status: _____ SSN: _____

Spouse/Legal Guardian Name: _____ Relationship: _____

Spouse/Legal Guardian DOB: _____ Spouse/Legal Guardian Phone: _____

Race (Please Choose Only One)
☐ I choose not to specify ☐ American Indian/Alaskan Native ☐ White/Caucasian ☐ Asian
☐ Native Hawaiian ☐ Pacific Island ☐ Black/African American ☐ Other: _____

Ethnicity (Please Chose Only One)
☐ I choose not to specify ☐ Not Hispanic or Latino ☐ Hispanic or Latino

Preferred Language (Please Chose Only One)
☐ I choose not to specify ☐ English ☐ Spanish ☐ American Sign Language ☐ Other: _____

CONTACT INFORMATION

Home: (_____)_____ Work: (_____)_____ Cell: (_____)_____
OK to leave detailed messages (i.e. appointments, billing, results, etc.)? ☐ Yes ☐ No
Would you like to receive text messages? ☐ Yes ☐ No

Emergency Contact: _____ Relationship: _____

Emergency Contact (Home/Work): _____ Emergency Contact (Cell): _____

May we discuss your health care information with the person listed above? ☐ Yes ☐ No

Neil Sandhu, MD, FAAD
Bianca Moon, MMS, PA-C
Ph: 386-628-DERM (3376)

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PRIMARY INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder's Name: _____

Policy Number/Member ID: _____

Group Number: _____

Policy Holder's DOB: _____/_____/_____ Policy Holder's Phone: _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance: _____

Policy Holder's Name: _____

Policy Number/Member ID: _____

Group Number: _____

Policy Holder's DOB: _____/_____/_____ Policy Holder's Phone: _____

MEDICAL PROVIDER AND PHARMACY INFORMATION

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 Aspire Dermatology & Aesthetics to release your medical record (including laboratory test results) to the provider(s) listed. IF NO PCP OR REFERRING PROVIDER PLEASE MARK NONE.

Primary Care Physician (PCP)	Referring Physician	Preferred Pharmacy
Name: _____	Name: _____	Name: _____
PH: _____	PH: _____	PH: _____
Fax: _____	Fax: _____	Fax: _____
City or Zip Code: _____	City or Zip Code: _____	City or Zip Code: _____
Did they refer you? ☐ Yes ☐ No		

CONSENT TO TREAT AND PAYMENT AUTHORIZATION

With my signature below, I voluntarily give consent for myself and/or my child to be examined and treated by the clinicians of Aspire Dermatology & Aesthetics. I also hereby assign and authorize payment of medical benefits to Aspire Dermatology & Aesthetics and payments may be made on my behalf directly for services rendered.

Signature: _____ Date: _____

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PATIENT HISTORY FORM

Name: _____ DOB: _____ Date: _____

PAST MEDICAL HISTORY

Do you have a history of the following?

☐ NONE
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Bone Marrow Transplant
☐ Breast Cancer
☐ Colon Cancer
☐ COPD
☐ Coronary Artery Disease
☐ Depression
☐ Diabetes
☐ End Stage Renal Disease
☐ Fainting
☐ Functional Murmur
☐ GERD
☐ Hay Fever
☐ Hearing Loss
☐ Hepatitis
☐ High Blood Pressure
☐ HIV / AIDS
☐ High Cholesterol
☐ Leukemia
☐ Liver/Stomach/Bowel Disease
☐ Lung Cancer
☐ Lymphoma
☐ Pacemaker placement
☐ Prostate Cancer
☐ Radiation Treatment
☐ Renal Disorder
☐ Rhythm Disorder
☐ Seizures
☐ Stroke
☐ Thrombophlebitis
☐ Thyroid Disorder
☐ Other: _____
_____
_____
_____

SKIN HISTORY

When you are exposed to the sun does your skin (choose one): ☐ Tan only ☐ Tan and Burn ☐ Burn

Have you ever had skin cancer or pre-skin cancer? ☐ No ☐ Yes, if so, what type?

☐ Melanoma ☐ Precancerous Moles (Dysplastic Nevus) ☐ Basal Cell Skin Cancer

☐ Squamous Cell Skin Cancer ☐ Actinic Keratosis ☐ Other: _____

Do you have a history of any specific skin diseases? _____

Have you had surgery in the last 6 months? ? ☐ No ☐ Yes, if so, what type? _____

Do you bleed easily or have known bleeding problems with previous skin excisions? _____

Do you premedicate with antibiotics before procedures? _____

Do you have any of the following:

☐ Mitral valve prolapsed ☐ Joint replacement ☐ Pacemaker/defibrillator

☐ Organ transplant ☐ Heart defect ☐ Artificial heart valve ☐ Heart murmur

Do you wear sunscreen? ☐ No ☐ Yes, if so, what SPF: _____

Do you tan in a tanning bed? ☐ No ☐ Yes, if so, how often: _____

Have you ever had a reaction to anesthesia (Lidocaine)? ☐ No ☐ Yes

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Name: _____ DOB: _____ Date: _____

MEDICATIONS

Please list all current medications with all the requested information (including any prescriptions, supplements, herbs, or OTC Medications). If you do not take any medications, please write NONE.
By providing a medications list, this allows us permission to import your prescription history from your pharmacy.

Please list names of any Medications, Herbs, Supplements	Dose	How many times a day

ALLERGIES

Are you allergic to: ☐ LIDOCAINE ☐ EPINEPHRINE ☐ ADHESIVES ☐ ANTIBIOTICS ☐ NONE

List all known Allergies AND Reactions: _____

FAMILY SKIN HISTORY

Do you have a family history of Skin Cancer? If so, what kind and which relative(s):

☐ Yes ☐ No Melanoma _____
☐ Yes ☐ No Basal Cell Carcinoma _____
☐ Yes ☐ No Squamous Cell Carcinoma _____
☐ Yes ☐ No Precancerous Moles (Dysplastic Nevus) _____
☐ Yes ☐ No Other _____

FAMILY HISTORY

Please indicate only 1st-degree relatives (mother, father, brother, sister, children):

☐ Breast Cancer ☐ Bleeding Disorder ☐ Colon Cancer ☐ Other: _____

_____

_____

SURGICAL HISTORY

Please list any major surgical procedures: _____

_____

_____

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Name: _____ DOB: _____ Date: _____

SOCIAL HISTORY

Smoking Status (please choose one):
☐ Never smoker
☐ Current every-day smoker
Number of Packs Per Day: _____
Total Years Smoking: _____

Alcohol Intake (please choose one):
☐ None
☐ 1 or less per day
☐ 1-2 per day
☐ 3 or more per day

Do you use recreational drugs?
☐ No
☐ Yes, if so, what, and how often? _____

Have you ever been exposed to HIV/AIDS? _____
Occupation and Type of Workplace: _____

REVIEW OF SYSTEMS

Please check all that apply:

☐ Allergy to Adhesive
☐ Allergy to lidocaine
☐ Allergy to topical antibiotics
☐ Artificial heart valve
☐ Artificial joints (within past 2 years)
☐ Blood thinners
☐ Diabetes
☐ Pre-diabetes or high blood sugar
☐ Require premedication prior to procedures
☐ Pacemaker/Defibrillator/Implant
☐ Sore throat
☐ Problems with healing
☐ Problems with bleeding
☐ Rapid heartbeat with epinephrine
☐ HIV/AIDS
☐ Hepatitis (A, B, or C)
☐ Immunosuppression
☐ Fevers or chills
☐ Pregnant or Planning a Pregnancy
☐ Currently Breastfeeding (lactating)
☐ History of Vasovagal Response/Fainting
☐ Seizures

REASON FOR TODAY'S VISIT

What are you here for today? _____

How long has this problem been present? _____

What makes this problem better or worse? _____

What other symptoms has this problem created? _____

Women: Are you pregnant? ☐ No ☐ Yes, if so, when is your due date? _____

If no, are you planning to become pregnant? _____ Are you currently breast feeding? _____

Referred by: ☐ Friend/Family _____ ☐ Physician _____

☐ Google ☐ Yelp ☐ Internet ☐ Advertisement ☐ Instagram ☐ Facebook ☐ Other: _____

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