Dermatology Practice
of the Carolinas, P.A.

12611 N. Community House Road
Suite 102 • Charlotte, NC 28277

Tel (704) 544-8200
Fax (704) 544-8300

Patient Information

CHART # Date of Birth

Name _____ Marital Status _____ Email _____ Age _____

Sex ☐ F ☑ M **Gender Identity:** ☐ Identify as Male ☐ Identify as Female ☐ Transgender Male/Trans Man (FTM)
☐ Transgender Female/Trans Woman (MTF) ☐ Other ☐ Genderqueer (Neither exclusively M or F) ☐ Choose Not to Disclose

Mailing Address: _____

Phone: Home (___ ,_____ _____ Cell (___, _____ _____ Work (___, _____ _____

Is it OK to leave a detailed message about your medical condition? Yes ☐ No ☐

Primary Care Physician _____ **Who Referred you to us?** Dr. _____

Practice Name _____ Phone # _____

SKIN CARE / AESTHETIC CONCERNS:

Would you like information about our cosmetic treatments and/or aesthetic services? YES ☐ NO ☐

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name of Insured _____ Relationship to patient _____

Date of Birth (of insured) ____ ___ _____

Mailing Address: _____

Phone: Home (___ , _____ _____ Cell (Work ___, _____ _____

ADVANCED CARE PLAN

Do you have a will? ☐ YES ☐ NO

Do you have a power of attorney in place in case you become incapacitated?

☐ No ☐ Yes - Contact Info _____

_____

PHARMACY INFORMATION

Preferred Pharmacy Name _____

Address and Phone Number _____

In case of Emergency, who should be notified (other than those already listed above)?

Name _____ Phone _____ Relationship _____

All of the above is correct to the best of my knowledge, and I agree to notify this office in a timely manner of any changes.

Patient or Responsible Party Signature _____ **Date** _____

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CHART # _____

History and Intake Form

Patient: _____ **DOB:** _____ **Today's Date:** _____

Reason for today's visit: _____

Past Medical History: (please circle all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ BPH
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ None

Other _____

Past Surgical History: (please circle all that apply)

- ☐ Appendix Removed
- ☐ Bladder Removed
- Mastectomy (Right, Left, Bilateral)
- Lumpectomy (Right, Left, Bilateral)
- Breast Biopsy
- Breast Reduction
- Breast Implants
- Colectomy: Colon Cancer Resection
- Colectomy: Diverticulitis
- Colectomy: IBD
- Gallbladder Removed
- Coronary Artery Bypass
- PTCA
- Mechanical Valve Replacement
- Biological Valve Replacement
- Heart Transplant
- Joint Replacement, Knee (Right, Left, Bilateral)
- Joint Replacement, Hip (Right, Left, Bilateral)
- Kidney Biopsy
- Kidney Removed
- Kidney Stone Removal
- Kidney Transplant
- Ovaries Removed: Endometriosis
- Ovaries Removed: Cyst
- Ovaries Removed: Ovarian Cancer
- Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- TURP
- Skin Biopsy
- Basal Cell Cancer Surgery
- Squamous Cell Carcinoma Surgery
- Melanoma Surgery
- Spleen Removed
- Testicles Removed (Right, Left Bilateral)
- Hysterectomy: Fibroids
- Hysterectomy: Uterine Cancer
- None

☐ Other _____

Skin Disease History: (please circle all that apply)

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- Blistering Sunburns
- Dry Skin
- Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- Melanoma
- Poison Ivy
- Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ None

Other _____

Do you wear Sunscreen? Yes No

If yes, what SPF? _____

CONTINUE ON PAGE 2

Do you tan in a tanning salon? Yes ☐No

Do you have a family history of Melanoma? Yes No If yes, which relative(s)? _____

Any general medical history of **immediate family**? Yes No If yes, indicate: ☐mother ☐father ☐brother ☐sister

_____

Have you had a Flu or Pneumonia vaccine? Yes No Date: _____

Medications: Please enter all current medications: _____

_____

Medical Allergies: (Please enter only **drug** allergies)

_____

Social History: (Please circle all that apply)

Currently Smokes - daily	Alcohol - none	
Currently Smokes - not daily	Alcohol - <1 drink daily	Drug Use
Has smoked in the past	Alcohol - 1-2 drinks daily	None
Has never smoked	Alcohol - ≥ 3 drinks daily	Other _____

Review of Systems: Are you currently experiencing any of the following?
(please check yes or no for the following)

Symptom	Yes	No
Immunosuppression		
Changing moles		
Rash		
Hay fever		
Wheezing		
History of melanoma		
Pacemaker		
Defibrillator		
Artificial joints within past two years		
Artificial heart valve		
Premedication prior to procedures		
Allergy to adhesive		
Allergy to topical antibiotic ointments		
Blood thinners		
Pregnancy or planning a pregnancy		
Breastfeeding or lactation		
Allergy to lidocaine		
Rapid heart beat with epinephrine		
Problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic or keloid)		
Yeast infections with antibiotics		
GI upset with antibiotics		
Fainting	☐	

Other Symptoms: _____

_____

_____

_____

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Authorization for Release of Information to Family and/or Friends

Patient: _____ DOB: _____

Dermatology of the Carolinas is authorized to release protected health information about the above-named patient to the entities named below:

Entity to Receive Information. INITIAL EACH that is subject to this authorization.

☐ –Leave Information on the voice mail ☐ Home ☐ Cell ☐ Work
Give Information to spouse.
☐ –Give information to the following person(s): _____ _____

Type of Information to share with above.

Financial Information
Family billing information
Information results from test or x-rays
Medical Information as follows:
Other information:

Rights of the Patient

I understand that I have the right to revoke the authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed in the document by signing a written notification to Dermatology Practice of the Carolinas. I understand that revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon signing this authorization.

This authorization shall be enforced and effective until revoked by the patient or representative signing the authorization.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name Patient or Representative