PUYALLUP DERMATOLOGY

PATIENT INFORMATION

Appointment Date _____

Last Name_____**First Name** _____ **M.I.** ____ **Birth Date** _____

Reason for appointment:_____How long has the issue been present? _____

Treatments/Therapies Tried? _____Have treatments/therapies helped? **YES / NO**

Were you referred to our office? **Yes / No**
Referring Physician Name:_____Clinic Name:_____Clinic Phone: (___) _____

List all medications you are taking, please include dosage and directions

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you take a daily Aspirin? YES / NO **Latex Allergy? YES / NO**

Known Medication Allergies? YES / NO **If yes, please specify allergy(s)and reaction type**:_____

SOCIAL HISTORY (circle)

Currently use tobacco products? YES / NO **If yes, please specify** cigarettes cigars chewing tobacco

Drink Alcohol: YES / NO **If yes, please specify how often:** Daily 1-3 drinks weekly Monthly

Do you have or have concerns that you might have AIDS/HIV? YES / NO

FEMALES: Are you or do you think you may be pregnant YES / NO

Please mark the following skin conditions that you or your family have a history of:

Condition	Self	Mother	Father	Grandparent	Sibling	Please explain
Psoriasis						
Basal Cell Carcinoma						
Squamous Cell Carcinoma						
Malignant Melanoma						
Other Skin Problem						

Patient Health History

Condition	Please explain	Condition	Please explain
Cancer other than skin cancer		Blood / Bleeding Disease	
Condition of the Eye/Nose, Throat, Mouth		Depression / other psychological disorder	
Allergies / Hay fever		Thyroid Disease	
Lung Disease / Asthma		Diabetes	
High Blood Pressure		Stomach / Bowl Disease/Liver Disease	
Heart Disease, Pace Maker, Defibrillator		Kidney / Bladder Problems	
Headaches / Stroke / Seizures		Arthritis / Muscle / Joint Disease	

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PATIENT INFORMATION **Appointment Date** _____

Last Name_____First Name _____ M.I. ____ Birth Date _____

If patient is a minor, Name of Parent/Guardian:_____

Social Security Number# _____

Preferred Language:_____ **Ethnicity/Race:**_____

Marital Status: Single Married Divorced Widowed

Gender at Birth: Male or Female

Gender Identity:_____**Gender Pronouns:** _____

Mailing
Address _____ Apt. #_____ City/State_____ ZIP Code _____

Home Phone (___) _____-_____ Cell Phone (___) _____- _____Email_____

Preferred method of contact? Home Phone Cell Phone Email

Can detailed messages with diagnosis and/or test results be left on your answering machine? YES - NO

Emergency Contact _____Relationship _____Phone (____) _____-_____

Employer_____Occupation _____

Primary Care Physician _____Office Phone (____) _____- _____

List any family members previously seen in our office _____

INSURANCE INFORMATION

◆ **If your insurance company requires a referral, contact your primary physician for approval.**

◆**Insurance cards must be presented at each appointment** ◆

Primary Insurance_____ Secondary Insurance _____

Subscriber _____ Subscriber _____

DOB _____ Employer _____DOB_____Employer _____

ID# _____ Grp# _____ID#_____ Grp#_____

THE PERSON SIGNING THIS FORM IS THE "RESPONSIBLE PARTY" FOR PAYMENTS

Patient Name _____

Signature of Patient (Parent or Legal Guardian) _____

Name of P**arent or legal guardian if signing** _____ Relationship_____

Patients less than 18 years of age are not permitted to sign form. Parent or Guardian must be present.

Revised 03/2025