WESTERN RESERVE DERMATOLOGY

PATIENT INFORMATION (Please Print) Date: ___/___/____

Name: _____
Last First M.I

Address: _____
Street City State Zip

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

Marital Status: S / M / W / D Date of Birth: ___/___/____ SS#: _____ Sex: ___ Age: ____

Referred by: _____ Primary Care Physician: _____

I give consent for text message reminders regarding appointments? ☐ YES ☐ NO

RESPONSIBLE PARTY or LEGAL GUARDIAN (If different from patient)

Name: _____ Relationship to patient: _____
Last First

Address: _____
Street City State Zip

Home Phone: (___) _____ Work Phone: (___) _____ SS#: _____

INSURANCE INFORMATION (Please provide copy of insurance card)

Primary Insurance Name: _____ PPO / HMO / POS ID#: _____

Name of Insured: _____ Insured's Employer: _____

Relationship to patient: _____ Insured's DOB: ___/___/___ Group#: _____

Secondary Insurance Name: _____ PPO / HMO / POS ID#: _____

Name of Insured: _____ Insured's Employer: _____

Relationship to patient: _____ Insured's DOB: ___/___/___ Group#: _____

Month insurance renews _____

ADDITIONAL INFORMATION

May we leave personal medical/billing information on your answering machine or voicemail? ☐ YES ☐ NO

Do you give our office permission to discuss your medical/billing information with family members? ☐YES ☐NO

If yes, please provide their names, relationship to patient, and their date of birth **OR** the last four digits of their SS# below:

Name/Relationship: _____ DOB: ___/___/____ Last 4 digits of SS#: _____

In case of emergency, who should be notified? _____

Relationship to patient: _____ Phone: (___) _____

By signing below I indicate that the information above is accurate and correct to the best of my knowledge and ability.

Patient / Guardian Signature: _____ Date: _____

CONTINUED ON BACK

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Date:_____ Name:_____ Age:____

Initial Visit: What are your main reasons for today's visit?

1._____

2._____

Symptoms associated with today's visit:

Location of condition on your body_____

Duration_____

Symptoms (itching, burning, pain) _____

Severity (mild, moderate, severe)_____

Timing (gradual or rapid onset)_____

Improving, worse or stable at this time?_____

Does the condition change in relation to sun, hobbies, work or stress?_____

Is your condition better or worse with medication?_____

What treatments have you tried?_____

Any feeling of fatigue / tiredness or loss of sleep?_____

Family History: Have any diseases been diagnosed in your family such as: psoriasis, eczema, hay fever, arthritis, asthma, melanoma, abnormal moles, high blood pressure, diabetes, etc?_____

_____

Medical /Surgical History: Have you been diagnosed with any illness or had surgery?_____

_____

_____

_____

What medications or supplements are you currently taking? _____

_____

Allergies:_____

Current social habits: Smoking _____ Drinking _____

Current Hobbies: _____

Current occupation: _____

Review of symptoms: any problem with these? Please circle.

Disorder of skin, hair, nails	Discomfort of mouth or nose	Swellings	Fever/Chills
Stomach or Bowel problems	Night sweats	Fatigue	Loss of weight
Breathing difficulties	Nausea or vomiting	Headaches	Change of vision
Tension/anxiety/depression	Joint pains	Chest pain	Muscle weakness
Nerve tingle/pain/numbness	Pain in back or heels	Appetite	Genitalia problems