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LUBBOCK DERMATOLOGY
AND SKIN CANCER CENTER WEST

Patient's Name_____ Date of Birth_____ SS# _____

Gender_____ Phone#_____

Address_____ City _____ State _____ Zip_____

Email Address_____ Occupation _____ Work #_____

Emergency Contact Name _____ Relationship _____ Phone #_____

Do we have permission to discuss your medical condition with your emergency contact? Yes No

Reason for Today's Visit _____ Referring Dr _____

Have you ever had dental anesthesia (Novocain)? Yes No Any bad reactions? Yes No

Primary Care Physician _____ Phone # _____

Are you allergic to any medications? Yes No If yes, please list _____

Pharmacy _____ Phone #_____

Please check any diseases or medical conditions you have or have had below:

| | **Lungs:** |
|---|---|
| | Bronchitis |
| | Emphysema |
| | Asthma |
| | Chronic Cough |
| | Morning Cough |
| | Shortness of Breath |
| | Wheezing |
| | **Cardiovascular:** |
| | High Blood Pressure |
| | Chest Pain |
| | Heart Attack |
| | Irregular Heartbeat |
| | Heart Murmur |
| | Phlebitis |
| | Inflammation of Veins |
| | Blood Clot |
| | Pacemaker |

| | **Other Systemic:** |
|---|---|
| | Diabetes |
| | Excessive Thirst |
| | Amputation |
| | Thyroid |
| | Kidney |
| | Dialysis |
| | Bladder (Frequency/Burning |
| | Gastrointestinal |
| | Nausea,Vomiting,Diarrhea |
| | Yeast Infection |
| | Arthritis/Joint Deformity |
| | Convulsions,Epilepsy or Seizures |
| | Fainting |

List any other medical diseases or conditions _____

List current medications 1. _____ 2. _____

3. _____ 4. _____ 5. _____

PLEASE COMPLETE OTHER SIDE…

6. _____ 7. _____ 8. _____

List any surgical procedures you have had in the last 6 months_____

**Skin**: Have you ever had skin cancer? **YES NO** Do you bleed easily? **YES NO**
Has anyone in your family had skin cancer? **YES NO** Do you have problems with healing? **YES NO**
Do you develop keloids (raised scars) after surgery? **YES NO** Do you have a history of specific skin disease? **YES NO**
Other_____

**Social History:**
Do you drink alcohol and/or do IV drugs? **YES NO** If yes, what? _____ How Often? _____ Daily / Weekly / Monthly
Do you smoke/vape? **YES NO** If yes, how much? _____ Daily / Weekly / Monthly

**Please Answer the following questions**
(Women) Are you pregnant? **YES NO** Due Date_____/_____/_____

*******Please be advised that when you have a biopsy and/or labs performed in the office, your tissue will be sent to an outside pathologist for testing. This will be a **separate charge** billed by the pathologist. Thank you for your understanding and we appreciate your business. Please initial _____

## HIPAA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Consent was Signed by: _____

Relationship to patient: _____

Date: _____