CAROLINA DERMATOLOGY
OF GREENVILLE

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Patient Information: Date: _____

First, MI, Last Name: _____ Date of Birth: _____

SSN: _____ Gender at birth: ☐Male ☐Female Identify as: ☐Male ☐Female

Full Address: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Race: _____ Ethnicity: _____ Need Interpreter: ☐Yes ☐No Language:_____

NOTE: If patient is a minor, provide Parent or Guardian Name, DOB, and Relationship below:

_____ /_____/_____

Address (if different from above): _____

Primary Care Provider: _____ Referring Provider: _____

Preferred Pharmacy and Location: _____

Insurance Information: (Please bring insurance card(s) to appointment.)

Primary Insurance: _____ ID No: _____

Secondary Insurance: _____ ID No: _____

Medical History:

Briefly, what brings you in today: _____

_____

Personal History of Skin Cancer: ☐Yes ☐No If Yes, Type: ☐Basal Cell Carcinoma ☐Squamous Cell Carcinoma ☐Melanoma ☐Other: _____

Family History of Skin Cancer: ☐Yes ☐No Family Member(s): _____

History of skin disease: ☐Yes ☐No If yes, what type? _____

List any other diseases or conditions you have: _____

Pregnant: ☐Yes ☐No If yes, how many weeks: _____ Breastfeeding: ☐Yes ☐No

Pacemaker/Defibrillator: ☐Yes ☐No Artificial Heart Valve: ☐Yes ☐No Joint Replacement: ☐Yes ☐No

HIV: ☐Yes ☐No Hepatitis B or C: ☐Yes ☐No Diabetes: ☐Yes ☐No Blood Thinner: ☐Yes ☐No _____

Personal History of Cancer: ☐Yes ☐No If yes, what type? _____

List Current Medications (dose not necessary):

Medication Allergies: ☐Yes ☐No If yes, which one(s)? _____