WELCOME! PLEASE COMPLETE ALL INTAKE FORMS IN THEIR ENTIRETY. THANK YOU!

MASTER REGISTRATION

Date: _____

Name: _____
Last First M.I.

Address: _____
Street City State Zip

Home Phone: (____) _____-_____ **Work Phone** (____) _____-_____ **Cell Phone**: (____) ____-_____

Date of Birth: (DOB) _____**Age**: _____ **Birth Gender**: _____ **SS #:** _____-_____-_____

Marital Status (circle one): Single Married Divorced Widowed Occupation: _____

In case of Emergency, who should be notified?

Name: _____**Phone**: (____) _____-_____**Relationship to the Patient**: _____

Parent of responsible party: *(if different from patient)*

Name: _____ **Phone**: (____) _____-_____

INSURANCE INFORMATION *(Please enter info if you are NOT the primary cardholder.)*

Primary Insurance
Insurance Company Name: _____
Policy Holder _____
Insured DOB _____
Employer Name _____
Relationship of patient to the Insured

Secondary Insurance
Insurance Company Name _____
Policy Holder _____
Insured DOB _____
Employer Name _____
Relationship of patient to the Insured _____

PATIENT PORTAL

A patient portal is a secure online website that provides patients convenient 24-hour access to personal health information, including recent doctor visits, visit summaries, lab results, prescriptions, and appointment information. Shortly after your visit today, you will receive an email with steps on how to access your personal information on the Patient Portal.

Email Address: (*APPOINTMENT CONFIRMATION AND OR PATIENT PORTAL ACCESS)*

☐ **CHECK THE BOX IF YOU WISH TO NOT RECEIVE AN EMAIL APPOINTMENT CONFIRMATION**

On occasion you will receive an emailed newsletter with office updates, special announcements, and industry news. We keep your information secure, and you will always have the opportunity to unsubscribe from the newsletter.

BACKGROUND

Race
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ African American
- ☐ Native Hawaiian
- ☐ White

Ethnicity
- ☐ Hispanic / Latino
- ☐ Non-Hispanic / Latino

Preferred Language
- ☐ English
- ☐ Spanish
- ☐ French
- ☐ Hindi
- ☐ Other _____

MASTER REGISTRATION

HEALTH INFORMATION DISCLOSURE

I allow the staff at Schaumburg Dermatology to discuss my medical and financial issues with the following person(s). This is valid until revocation is given in writing. (If you do not want us to share this information, write "NONE" next to the first Name below.)

Name: _____ Phone: (____) _____-_____ Relationship to the Patient: _____

Name: _____ Phone: (____) _____-_____ Relationship to the Patient: _____

MESSAGES FOR LAB RESULTS

Only select (X) **one** box below. Please read carefully.

☐ I Authorize Schaumburg Dermatology to leave voicemails with details of my appointments and results on the following numbers (check all that apply): _____ Home phone ____ Cell phone ____ Work phone

☐ I do not want appointment information and results left on voicemails. If this box is selected, Schaumburg Dermatology staff will only leave a message for you to call our office back.

PARENTAL RELEASE OF MINORS

I allow my child, _____ to come for his/her office visits alone unsupervised and will allow for treatment discussion, prescribing of medications, and procedures to be performed as deemed medically appropriate for my child's condition. This authorization will be valid until revocation is given in writing.

_____

Signature of Parent or Legal Guardian Date

_____

Print Name of Legal Guardian Relationship to patient

ACKNOWLEDGEMENT

I acknowledge that I have read this entire form and have answered all questions truthfully and to the best of my ability.

_____

Signature of Patient or Legal Guardian Date

Schaumburg DERMATOLOGY

For Office Use Only
Appt Time: _____
Provider: Dr. Singri Sonal PA-C
FDC Initials : _ MA Initials:

PATIENT HISTORY FORM

Date: _____

Patient Name: _____ **AKA**:_____ **DOB**:_____ **AGE**:_____ **Gender:**_____

Address By: She/Her/Miss/Mrs. ( ), He/Him/His/Mr. ( ), They/Their/Them/Mx ( )

Purpose of today's visit (chief complaint):_____

How did you hear about us? _____

Primary Care Physician: _____ Phone Number: _____
Address:_____

Local Pharmacy Name: _____ Phone Number: _____
Address:_____

Mail Order Pharmacy: _____ Phone Number: _____

ALLERGIES (*to drugs, foods, antibiotic ointment, latex*): _____

CURRENT (OR PAST) MEDICAL PROBLEMS

Have you ever had or currently have any of the following?

☐ Seasonal Allergies	☐ Hives	☐ Lung Disease	☐ Heart disease
☐ Eczema	☐ Psoriasis	☐ Arthritis	☐ High blood pressure
☐ Asthma	☐ High cholesterol	☐ Diabetes	☐ Tuberculosis (TB)

☐ Cancer (Specify type of cancer and treatment): _____

CURRENT (OR PAST) MEDICAL PROBLEM - if not specified already *(If yes, please explain)*

Eyes:	☐YES	☐NO	_____
Ears/ Nose/ Throat/ Mouth:	☐YES	☐NO	_____
Cardiovascular (heart issues):	☐YES	☐NO	_____
Respiratory (lung issues):	☐YES	☐NO	_____
Gastrointestinal (stomach, bowel issues):	☐YES	☐NO	_____
Genitourinary (kidney, bladder, urinary):	☐YES	☐NO	_____
Musculoskeletal (bones, muscles):	☐YES	☐NO	_____
Neurological (headaches, seizures):	☐YES	☐NO	_____
Psychiatric (anxiety, depression, etc.):	☐YES	☐NO	_____
Thyroid/ Endocrine:	☐YES	☐NO	_____
Hematology (bleeding disorder, etc.):	☐YES	☐NO	_____
Herpes/Cold Sores	☐YES	☐NO	If *yes, location*: _____
Other			_____

SKIN HISTORY

When was your last skin cancer screening?_____ ☐ Never
(MM/YYYY OR YYYY)

Personal history of skin cancer (*e.g., melanoma, basal cell skin cancer, squamous cell skin cancer):* ☐YES ☐NO
Type:_____ Location on body: _____ Treatment: _____ Year: _____

*****If additional space is needed for skin cancer history, please document on the backside of this form. *****

Please check if you have any of these risk factors for skin cancer: If none, please indicate ☐ NONE

☐ Hair: Blonde / red	☐ Personal history of melanoma	☐ History of actinic keratoses
☐ Eyes: Blue /green/ gray	☐ History of dysplastic (atypical) moles	☐ Family history of melanoma
☐ Numerous moles	☐ Worked 3 or more years outdoors	☐ 3 or more blistering sunburns

☐ Taking a high-risk medication for skin cancer: _____
☐ Tanning bed usage (Currently? (Yes/ No) Approx. total # of sessions in your lifetime? _____

PATIENT HISTORY FORM

Do you have any of the following: ☐ N/A ☐ Pacemaker ☐ Defibrillator ☐ Metal Implants (If *so, where?)* _____

VACCINE	Yes	No	Unknown	DATE ADMINISTERED
Influenza				
Pneumococcal				
Zoster (Shingles)				
Tdap (protects against tetanus, diphtheria, and whooping cough)				

Cis Females: Are you pregnant? ☐ YES ☐ NO *If so, how many weeks?* _____
Are you breastfeeding? ☐ YES ☐ NO

SURGERIES: ☐ N/A _____

FAMILY MEDICAL HISTORY ☐ Family history is not known ☐ Patient is adopted

☐ Allergies	☐ Hives	☐ Lung Disease	☐ Heart disease
☐ Eczema	☐ Psoriasis	☐ Arthritis	☐ High blood pressure
☐ Asthma	☐ High cholesterol	☐ Diabetes	☐ Tuberculosis (TB)

☐ Cancer: (specify type): _____

Family history of skin cancer? ☐YES ☐NO *If yes, specify type of skin cancer and family member's relationship to you (e.g., father, maternal aunt, etc.)*

_____

SOCIAL HISTORY

Occupation: (or Previous occupation) _____ ☐ **Homemaker** ☐ **Retired** ☐ **Unemployed** ☐ **Disabled**

☐ **Student (Name of school / year in school):** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐Other: _____

Tobacco/Vape/Marijuana Use? *If yes, indicate below*

Cigarettes/ E-cigarettes #_____ pack/day Cigars # _____ day/month Chewing Tobacco # ____ day/week Marijuana ☐YES ☐NO ☐ **Ex-smoker** ☐ **Never Smoked**

Alcohol Use: ☐YES ☐NO If yes, please specify #of drinks _____ day/ week / month

Recovered from substance abuse: *Please circle:* Alcohol/ Drug/ N/A

MEDICATIONS: List any medications you currently take. (This includes prescription medications, as well as over the counter medications/ vitamins/ supplements. Do not include dosages.) If you have a list, please provide a copy (and no need to complete below).

1.	**6.**	**11.**	**16.**
2.	**7.**	**12.**	**17.**
3.	**8.**	**13.**	**18.**
4.	**9.**	**14.**	**19.**
5.	**10.**	**15.**	**20.**

CONTINUED FROM PAGE 3 **– Personal history of skin cancer, continued:**

Type: _____ Location on body: _____ Treatment: _____ Year: _____
Type: _____ Location on body: _____ Treatment: _____ Year: _____
Type: _____ Location on body: _____ Treatment: _____ Year: _____
Type: _____ Location on body: _____ Treatment: _____ Year: _____