REGIONAL DERMATOLOGY

DEDICATED • INTEGRATED • ELEVATED

Patient Name: _____ Date of Birth: _____ SSN: _____
(LAST, FIRST, MI)

Address: _____ Phone: _____
(ADDRESS, CITY, STATE, ZIP CODE)

Emergency Contact: _____ Relation: _____ Phone: _____

Primary Care Dr.: _____ Referring by: _____

Email: _____ Preferred Pharmacy: _____
(NAME, CITY/STREET)

Gender Identity: _____ Assigned Gender: _____

REASON FOR TODAY'S VISIT: _____
(LIST REASONS HERE)

Patient "past" Medical History If no medical history, check here: ☐	Patient history Check if applies	Family history Check if applies	Pertinent Details
NEUROLOGIC ISSUES/ANXIETY			
CARDIAC/HEART HISTORY			
RESPIRATORY/BREATHING DISEASE			
GENITOURINARY DISEASE			
GI/ABDOMINAL DISORDER			
IMMUNOSUPPRESSION/AUTOIMMUNITY			
JOINT PAIN/ARTHRITIS			
ENDOCRINE/DIABETIC/THYROID DISORDER			
ECZEMA/PSORIASIS/SKIN DISORDER			
HX OF SKIN CANCER			
HX OF MELANOMA			
HX OR CURRENT CANCER AND TYPE			
OTHER CONDITION (NOT YET SPECIFIED)			

ALCOHOL USE: ☐ No alcohol use ☐ Alcohol use socially ☐ Alcohol use daily

SMOKING HISTORY: ☐ No tobacco use ☐ Current tobacco use (including chewing tobacco)

Prior smoking/tobacco/vaping history? ☐ Yes ☐ No

WEST | 15320 Conway Rd | Chesterfield, MO 63017
t 636.237.0030 | f 636.933.5900 | info@regionaldermatology.com

SOUTH | 1463 US-61, Suite B | Festus, MO 63028
t 636.933.7600 | f 636.933.5900 | info@regionaldermatology.com

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ALLERGY TO MEDICATIONS?

If none, check here: ☐

Medication	Reaction

LIST OF MEDICATIONS INCLUDING VITAMINS, SUPPLEMENTS, ASPIRIN & BLOOD THINNING MEDS (INCLUDE DOSE)

If none, check here: ☐

PLEASE NOTE: Our office will submit your bill to your insurance company. Please be sure to let us know of any changes you have to your insurance, your address and phone number on each visit. **In the event there are allowable charges that are not paid by your insurance company we may issue a bill to you from our office.** I understand that I will be responsible for any charges incurred that my insurance company does not pay including, but not limited to: copays, deductibles or other such allowable charges. **Signature below acknowledges this agreement.**

Responsible Party Signature: _____ **Date:** _____

IN ORDER TO BEST SERVE OUR PATIENTS, WE REQUEST ONLY TWO INDIVIDUALS IN THE ROOM: PATIENT AND ONE COMPANION. WE ALLOW MOBILE PHONES BUT REQUEST THEY BE SET ON SILENCE/VIBRATE, TO ENSURE WE MAY FOCUS ON YOUR HEALTHCARE NEEDS.

THANK YOU FOR CHOOSING REGIONAL DERMATOLOGY FOR YOUR SKIN CARE. WE APPRECIATE WORKING WITH YOU ON YOUR HEALTHCARE NEEDS!

Remember our telehealth for refill requests, for your busy schedule.

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