TURNER
DERMATOLOGY

TURNER DERMATOLOGY INTAKE FORM

Name: _____ Email:_____

Address:_____

Date of Birth: _____ Today's Date:_____

Home #:_____ Cell #:_____

How did you hear about us? _____

Is it ok to leave a detailed message on your voicemail regarding biopsy results? Yes/No

If yes, what phone number do you prefer?: _____

I give permission for test results and protected health information to be released to the following:

_____: Relationship:_____

_____: Relationship: _____

Pharmacy Information:

Name: _____

Zip Code: _____

Phone #: _____

Primary Care:

Name: _____

Group: _____

Office #: _____

Cigarette Smoking:

Never Smoked

Former Smoker

Quit: _____

Active Smoker

Alcohol Consumption:

Do you drink: Yes/No

___less than 1 drink per day

___ 1-2 drinks per day

___ 3 or more drinks per day

Are you pregnant or nursing? Yes/No

Do you have advanced directive? Yes/No

Past Medical History:

Anxiety Arthritis Asthma Depression Elevated Blood Pressure

Epilepsy GERD Hearing Loss HIV/AIDS Leukemia Malignant Lymphoma

Radiation therapy Implantable devices (pacemaker, etc.) Seizures Stroke

Hypo/Hyperthyroidism Cancer: _____

Other: _____

Past Surgical History: _____

_____

Skin Disease History:

Acne Actinic Keratosis Basal Cell Carcinoma Eczema Malignant Melanoma

Psoriasis Contact Dermatitis Squamous Cell Carcinoma Sunburn of second degree

Other: _____

Family History of Skin Cancer: _____

_____

Medications:

_____

_____

Allergies:

_____

_____

Do you have cosmetic questions? Yes/No

What cosmetic concerns do you have? _____

_____

I have read, understand, and will comply with the information within the following policies:

1. Turner Dermatology Financial Policy and Billing Process
2. Turner Dermatology Notice of Privacy Practices, HIPAA and Email Policy
3. Turner Dermatology Patient and Family Rights and Responsibilities

X_____

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