CHARLESTON DERMATOLOGY

Adam Sperduto, MD
Roger Sullivan, MD
Lee Yarbrough, MD
Ashley Allen, MD

Last name: ______________________ First Name: ______________________ MI: _____

Date of Birth: ______________ Age: ________ Gender: Male / Female Marital Status: ________

Street Address: ____

City, State, Zip Code: ____

Phone Number ______________________________ Can we text you? YES NO

Can we email you? No Yes, my email address is ______________________________

In case of emergency: ____

Relationship: ______________________ Phone Number: ______________________

RESPONSIBLE PARTY INFORMATION

- if not patient -

Last name: ______________________ First Name: ______________________

Date of Birth: ______________ Gender: Male / Female Phone Number: ______________________

Address (if different than patient) ______________________________

City, State, Zip Code: ____

X____

Signature Date

↩ PLEASE SEE BACK SIDE ↪

*Do you smoke any tobacco products: YES NO

*If you are ages 11-13 years old, have had any of the following. _________ MMR _________ TDAP _________ Gardasil

*If you are over the age of 60 and would like to list a surrogate decision maker, please give their information below.

Name Relationship Phone Number

____

RELEASE OF PERSONAL HEALTH INFORMATION

Any physician, staff, employee or representative of Charleston Dermatology, PC has my permission to discuss my account and medical conditions, which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information, with the following persons in order to facilitate and coordinate my care, treatment and payment:

Name Relationship Phone Number

____

Name Relationship Phone Number

____

Our practice can text you with benign test results, lab results or prescription information
Do you consent to benign test results , lab results or prescription information via text message? YES NO

__________ I authorize the release and disclosure of any or all of my medical and treatment records or report to any other health care provider who may be of assistance. In the opinion of Charleston Dermatology, PC and /or for assisting in any reimbursement or medical benefits to which the patient may be entitled. *I allow fax transmittal of my medical records, if necessary

__________ I further authorize and request that insurance payments be made directly to Charleston Dermatology, PC should they elect to receive such payment. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original. *I acknowledge full financial responsibility for services rendered by Charleston Dermatology, PC including those which may not be considered covered by my insurance policy. I understand that payment of charges incurred is due at time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default in payment of my charges.

__________ I authorize treatment by Charleston Dermatology, PC physicians and personnel.

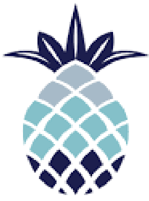
__________ I am aware that there is a NO SHOW Fee of $25 for any appointment that I do not attend, cancel or reschedule.

NOTICE OF PRIVACY PRACTICES

☐ I decline a copy of the Notice of Privacy Practices ☐ I would like a copy of the Notice of Privacy Practices

X____

Signature Date



Medical History

Name:____ Date of Birth:______________________

Have you ever had skin cancer? (please check all that apply)

☐ None ☐ Basal cell carcinoma ☐ Squamous cell carcinoma ☐ Melanoma skin cancer

Do you have a family history of melanoma skin cancer?

☐ No ☐ Yes, please mark which ☐ Mom ☐ Dad ☐ Sibling

Medical History (please check all that apply)

☐ None
☐ Allergies/Hay fever
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial fibrillation
☐ Autoimmune disease
____
☐ Bone marrow transplantation
☐ BPH (enlarged prostate)
☐ Breast cancer history
☐ COPD
(chronic obstructive pulmonary disease)

☐ Coronary Artery Disease
☐ Depression
☐ Diabetes
☐ Eczema
☐ GERD
☐ Hearing Loss
☐ Hepatitis
☐ High blood pressure
(hypertension)
☐ HIV/AIDS
☐ High cholesterol
☐ Hyperthyroidism
☐ Hypothyroidism

☐ Kidney Disease
☐ Leukemia
☐ Lung Cancer
☐ Lymphoma
☐ Pacemaker or defibrillator
☐ Prostate Cancer
☐ Psoriasis
☐ Radiation treatment
☐ Seizures
☐ Stroke
☐ Other (please specify)
____

Past Surgical History (please check all that apply)

☐ None
☐ Appendix
☐ Breast ______________
☐ Colon ______________
☐ Gallbladder
☐ Heart: **biological valve replacement**

☐ Heart: **coronary artery bypass surgery**
☐ Heart: **mechanical valve replacement**
☐ Heart: **stent placement**
☐ Heart: **transplant**
☐ Kidney transplant
☐ Liver transplant

☐ Splenectomy
☐ Tonsillectomy
☐ Joint replacement (please specify)_______________
☐ Other (please specify)
____

Medications

☐ None ☐ Please see attached list

_________________________ _________________________ _________________________
_________________________ _________________________ _________________________
_________________________ _________________________ _________________________

Allergies

☐ Adhesive (medical tape)
☐ Latex
☐ Lidocaine

☐ Neosporin
(or other topical antibiotic)
☐ Penicillin

☐ Sulfa
☐ Other (please specify)
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