CHARLESTON DERMATOLOGY

Adam L. Sperduto, M.D. | Roger P. Sullivan, M.D. | Lee C. Yarbrough, M.D. | Ashley Allen, M.D.
Julie Shaheen, PA-C | Chris Buthorn, PA-C | Deb Hewlett, PA-C
Anna Cate Smith, PA-C | Samantha Peters, PA-C | Carleigh Newman, PA-C

Last Name _____ First 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 in a first degree relative?

☐ No ☐ Yes, please circle all that apply: Parents Sibling Child

Do you: ☐ Smoke tobacco products ☐ Vape ☐ Drink alcohol: how many drinks per week? _____

Are you: ☐ Trying to conceive ☐ Pregnant ☐ Breastfeeding

Ages 11-13 years old, have had: ☐ MMR ☐ TDAP ☐ Gardasil

Over the age of 65, have you had a pneumonia vaccine? ☐ No ☐ Yes, date received _____

Medical History (please check all that apply)

☐ None
☐ History of melanoma
☐ Eczema
☐ Allergies/Hay fever
☐ Asthma
☐ Psoriasis
☐ High blood pressure
☐ High cholesterol
☐ Diabetes
☐ Hepatitis or liver disease
☐ Kidney Disease
☐ HIV/AIDS
☐ Immunocompromised
☐ Lymphoma/ Leukemia
☐ Autoimmune disease (please specify)
_____
☐ Bone marrow transplantation
☐ Rheumatoid Arthritis
☐ Cancer (please specify)
_____
_____
☐ Anxiety and/or Depression
☐ Coronary artery disease
☐ History of stroke
☐ Atrial fibrillation
☐ Artificial Heart Valve
☐ Defibrillator
☐ Pacemaker
☐ Watchman
☐ Seizures
☐ Thyroid Disease (please specify)
_____
☐ Other (please specify)
_____

↩ **PLEASE SEE BACK SIDE** ↪

Allergies (please check all that apply)

☐ None
☐ Latex
☐ Lidocaine
☐ Penicillin
☐ Sulfa
☐ Adhesive (medical tape)
☐ Neosporin/topical antibiotic
☐ Other (please specify)
_____

Past Surgical History (please list your surgical history)

☐ None ☐ Please see attached list

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Medications

☐ None ☐ Please see attached list

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Preferred Pharmacy

Name and Street _____

Primary Care Provider

Name _____

X_____
Signature Date

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Last name _____ First Name _____ MI _____

Date of Birth _____ Age _____ Male / Female Phone Number _____

Street Address _____ City, State, Zip Code _____

*Can we text you? ☐ YES ☐ NO *Can we leave a detailed voicemail? ☐ YES ☐ NO

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

Can we email you? ☐ NO ☐ Yes, my email address is _____

RESPONSIBLE PARTY INFORMATION

- if not patient -

Last name _____ First Name _____ MI _____

Date of Birth _____ Relationship _____ Male / Female Phone Number _____

Street Address _____ City, State, Zip Code _____

IN CASE OF EMERGENCY

Last name _____ First Name _____

Phone Number _____ Relationship _____

↩ PLEASE SEE BACK SIDE ↪

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

_____ 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, for assisting in any reimbursement or medical benefits to which the patient may be entitled, for fax transmission of my medical records, if necessary, to my primary care physician and any physician that is involved in my care and to be released to myself anytime requested without having to sign an individual release for each request.

_____ 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 and am aware that there is a NO SHOW Fee of $25 for any appointment that I do not attend, cancel or reschedule 24 hours prior to the time of the appointment.

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