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

<u>*Our practice can text you with benign test results, lab results or prescription information*</u>

*Do you consent to benign test results , lab results or prescription information via text message? YES NO

Please list your email address if we can email you

_____

RESPONSIBLE PARTY INFORMATION

- if not patient -

Last name _____ First Name _____ MI _____

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

Street Address - if different than patient - _____ City, State, Zip Code _____

IN CASE OF EMERGENCY

Last name _____ First Name _____

Phone Number _____ Relationship _____

↩ PLEASE SEE BACK SIDE ↪

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

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

- 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

CHARLESTON
DERMATOLOGY

Patient Name: _____

Patient Date of Birth: _____

Social Drivers Questionnaire

___ I do not want to answer the Social Drivers questionnaire

____ I have other reasons for which I do not want to answer the Social Drivers Questionnaire

Domain	Question	Response	
Healthcare	In the past month, did poor physical or mental health keep you from doing your usual activities, like work, school or a hobby?	Yes	No
	In the past year, was there a time when you needed to see a doctor but could not because it cost too much?	Yes	No
Food	Do you ever eat less than you feel you should because there is not enough food?	Yes	No
Employment & Income	Do you have a job or other steady source of income?	Yes	No
Housing & Shelter	Are you worried that in the next few months, you may not have safe housing that you own, rent, or share?	Yes	No
Utilities	In the past year, have you had a hard time paying your utility company bills?	Yes	No
Childcare	Does getting childcare make it hard for you to work, go to school or study?	Yes	No
Education	Do you think completing more education or training, like finishing a GED, going to college, or learning a trade, would be helpful for you?	Yes	No
Transportation	Do you have a dependable way to get to work or school and your appointments?	Yes	No
Clothing & Household	Do you have enough household supplies? For example, clothing, shoes, blankets, mattresses, diapers, toothpaste, and shampoo.	Yes	No
General	Would you like to receive assistance with any of these needs?	Yes	No
	Are any of your needs urgent?	Yes	No