DIVINE
Dermatology

Name	_____
DOB	_____
Today's Date	_____

Clinical Intake

Past Medical History

Yes	No	
☐	☐	Autoimmune Disease
☐	☐	Bowel / stomach disease
☐	☐	Internal Cancer
☐	☐	Genital Disease
☐	☐	Heart Attack
☐	☐	Infectious Disease
☐	☐	Kidney Disease
☐	☐	Liver Disease
☐	☐	Lung Disease
☐	☐	Seizures
☐	☐	Do you have a stent?
☐	☐	Stroke

Current Medications

_____

_____

_____

_____

_____

_____

_____

_____

Review of Systems

Yes	No	
		Problems with your immune system
☐	☐	Do you take medications that lower your immune system?
☐	☐	Do you faint with procedures
☐	☐	Blood Thinners
☐	☐	History of MRSA
☐	☐	HIV/ AIDS/ Hepatitis C
☐	☐	Premedicate prior to procedure
☐	☐	Pregnant or trying to get pregnant
☐	☐	Breastfeeding

Skin Cancer History

Yes	No	
☐	☐	Non- Melanoma Skin Cancer
☐	☐	Melanoma (Prior to becoming our patient)

If yes, what year? _____

Lymph nodes removed? _____

Allergies

Please list all allergies to medicatinos and the reaction you have (if non write NONE)

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Required CMS Questions

All Patients	Check all that apply to you:	☐ Never Smoked ☐ Former Smoker ☐ Current Smoker

All patients under the age of 18	Have you ever recieved any of these vaccinations? (Select all that apply)	☐ One (1) Meningococcal Vaccine ☐ One (1) TD ☐ One (1) Tdap Vaccine ☐ Three (3) HPV Vaccinations

All Patients 65 and older	Check all that apply to you:	☐ Living Will ☐ Health Proxy ☐ None

Which statement best reflects your wishes on advance care reccommendations? **(select one)**

☐ **Full Code:** I wish to have fill cardiopulmonary resuscitation efforts to be made.

☐ **Do Not Intubate:** I do NOT wish to have a breathing tube, even if it is required for life saving measure

☐ **Do Not Resuscitate**: In the even that my heart was to stop, I do NOT wish to have chest compressions or an AED to restart my heart, even if it is required for life saving measures.

Health care proxy name & contact number :

Please provide copies of legal documents to our team

Patient Registration

Demographics:

Name:
Date of Birth :
Address:
Email:
Preferred Phone #:

Communications

We protext your privacy by using advanced software. ***You will receive the best service by allowing text messages.*** We ***NEVER*** sell patient data to 3rd party marketing companies.

We have permission to:	Yes	No	
	☐	☐	Leave a voicemail
Note: HIPAA requires us to inform you that all patients	☐	☐	Send email notifications
accept responsibility associated with protecting their	☐	☐	Send text reminders and results
own voice, email, and text notifications.			

Minor Patients Only

Full name of Policy Holder:_____
(as it appears on the insurance card) Relationship to Patient:_____

Date of Birth :_____/_____/_____ Gender: **Male** / **Female** Phone Number:_____

Address:_____ City:_____ State:_____ Zip Code:_____

I acknowledge all of the above information is correct:

_____
Patient / Legal Guardian Signature