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 medications and the reaction you have (if non write NONE)

DIVINE
Dermatology

Name:_____

DOB: _____

Today's Date: _____

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 received 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 recommendations? **(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 event 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 protect 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