PATIENT INFORMATION *(Please Print)* Today's Date __/__/__

Name _____ SS # _____
First MI Last

Mailing Address _____
City State Zip

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____
Area Code Area Code Area Code

Preferred Contact #: ☐Home ☐Cell ☐Work Okay to leave message? ☐Home ☐Cell ☐Work

Email Address _____

Date of Birth _____ Age_____ Sex_____ Marital Status _____

PARENT OR RESPONSIBLE PARTY *(person responsible for this account, if different from patient)*

Name _____ Date of Birth _____ Sex _____
First MI Last

Mailing Address _____
City State Zip

Home Phone (____) _____ Work Phone (____) _____ SS # _____
Area Code Area Code

INSURANCE INFORMATION *(Please present insurance card(s) at time of check in)*

Primary Insurance _____ Secondary Insurance _____

Policy Holder _____ Policy Holder _____

Insured's Date of Birth _____ Insured's Date of Birth _____

Social Security # _____ Social Security # _____

Insured's ID # _____ Insured's ID # _____

Group # _____ Group # _____

Employer Name _____ Employer Name _____

Employer Phone (____) _____ Employer Phone (____) _____
Area Code Area Code

Relationship of insured to the patient _____ Relationship of insured to the patient _____

In case of emergency, who should be notified _____ Phone _____

Referred by _____

Primary Care Physician _____ Phone _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions.

I also authorize payment of medical benefits to the health care provider.

Patient or Responsible Party Signature _____ Date _____

DAWKINS DERMATOLOGY ASSOCIATES

MARK A. DAWKINS, M.D.
DIPLOMATE OF THE AMERICAN BOARD OF DERMATOLOGY

SUNITA CRITTENDEN, M.D.
DIPLOMATE OF THE AMERICAN BOARD OF DERMATOLOGY

KELLY WALWORTH, PA-C
DERMATOLOGY PHYSICIAN ASSISTANT

BRENDA LIVINGSTON, R.N.
MEDICAL AESTHETIC SPECIALIST

A. JORDAN HINTZE, PA-C
DERMATOLOGY PHYSICIAN ASSISTANT

NAME_____ **DOB**_____ **EMAIL**_____

NEW PATIENT

Past Medical History

SELECT ANY OF THE FOLLOWING MEDICAL CONDITIONS THAT YOU CURRENTLY HAVE

- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation (Irregular Heartbeat)
- ❑ Bone Marrow Transplantation
- ❑ BPH (Benign Prostatic Hyperplasia)
- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ COPD
- ❑ Coronary Artery Disease
- ❑ None
- ❑ Depression
- ❑ Diabetes
- ❑ End Stage Renal Disease
- ❑ GERD (Acid Reflux)
- ❑ Hearing Loss
- ❑ Hepatitis
- ❑ Hypertension (High BP)
- ❑ HIV/AIDS
- ❑ Hypercholesterolemia (High Chloesterol)
- ❑ Hyperthyroidism (High Thyroid)
- ❑ Hypothyroidism (Low Thyroid)
- ❑ Leukemia
- ❑ Lung Cancer
- ❑ Lymphoma
- ❑ Prostate Cancer
- ❑ Radiation Treatment
- ❑ Seizures
- ❑ Stroke
- ❑ Other (Please List)_____

PLEASE LIST PAST SURGERIES

_____

_____

Skin Disease History

HAVE YOU HAD ANY OF THE FOLLOWING SKIN CONDITIONS

- ❑ Acne (Teenage)
- ❑ Actinic Keratoses (Pre Cancers)
- ❑ Basal Cell Skin Cancer
- ❑ Blistering Sunburns
- ❑ Dry Skin
- ❑ Eczema
- ❑ Flaking or Itchy Scalp
- ❑ Other_____
- ❑ Hay Fever/Allergies
- ❑ Melanoma
- ❑ Poison Ivy
- ❑ Precancerous Moles
- ❑ Psoriasis
- ❑ Squamous cell skin cancer
- ❑ None

DO YOU WEAR SUNSCREEN?

❑ **Yes** ❑ **No**

IF YES, WHAT SPF?

_____

DO YOU TAN IN A TANNING SALON?

❑ **Yes** ❑ **No**

RACE: ❑ White ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or other Pacific Island ❑ Other_____

ETHNICITY: ❑ Hispanic or Latino ❑ NOT Hispanic or Latino

Family History

DO YOU HAVE A FAMILY HISTORY OF MELANOMA?

❑ **Yes** ❑ **No**

IF YES, WHICH RELATIVE?

_____

(Please complete form on back of page.)

13174 N. MACARTHUR OKLAHOMA CITY, OKLAHOMA 73142 Office: (405) 721-5555 Fax: (405) 470-7093

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(Continued from front.)

MEDICATIONS?

❑ Yes ❑ No Please List: _____

ALLERGIES TO MEDICATIONS?

❑ Yes ❑ No Please List: _____

Have you received an influenza immunization (flu shot) this year? ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No

If yes, how many times in the past year have you had 5 or more drinks in a day? _____

Have you ever received a pneumococcal (pneumonia) vacccination? ❑ Yes ❑ No

SMOKING STATUS?

❑ Never Smoked ❑ Former Smoker ❑ Current Smoker

Started Smoking _____ Quit Smoking _____ Number of packs/day _____ Total Years Smoking _____

Review of Systems (Are you Currently Having):

	Yes	No		Yes	No
problems with bleeding	❑	❑	seizures	❑	❑
problems with healing	❑	❑	shortness of breath	❑	❑
problems with scarring (hypertrophic or keloid)	❑	❑	sore throat	❑	❑
immunosuppression	❑	❑	thyroid problems	❑	❑
changing mole	❑	❑	unintentional weight loss	❑	❑
rash	❑	❑	wheezing	❑	❑
abdominal pain	❑	❑	pacemaker	❑	❑
anxiety	❑	❑	defibrillator	❑	❑
bloody stool	❑	❑	artificial joints within the past two years	❑	❑
bloody urine	❑	❑	artificial heart valve	❑	❑
blurry vision	❑	❑	premedication prior to procedures	❑	❑
chest pain	❑	❑	allergy to adhesive	❑	❑
cough	❑	❑	allergy to topical antibiotic ointments	❑	❑
depression	❑	❑	blood thinners	❑	❑
fever or chills	❑	❑	pregnancy or planning a pregnancy	❑	❑
headaches	❑	❑	allergy to lidocaine	❑	❑
hay fever	❑	❑	rapid heart beat with epinephrine	❑	❑
joint aches	❑	❑	yeast infections with antibiotics	❑	❑
muscle weakness	❑	❑	GI upset with antibiotics	❑	❑
neck stiffness	❑	❑	West Africa: Travel or Contact	❑	❑
night sweats	❑	❑			

Pharmacy Name _____ **Pharmacy Phone Number** _____

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