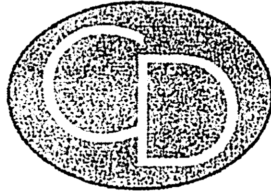

Cheshire Dermatology

Thank you for choosing Cheshire Dermatology for your dermatological needs, enclosed please find the demographic paperwork needed for your upcoming appointment. Please be sure to fill out forms completely prior to your visit, as well as your insurance card and copay if applicable. **All paperwork needs to be completed before arriving for your appointment. We will need to reschedule appointment if you do not have your paperwork with you.** Please do not mail paperwork back to office, bring it with you at your scheduled appointment time.

Check in process when you arrive to our office:
Please remain in your car.
Please dial 203-600-8851
Our front desk staff will go over a COVID questionnaire as well as some demographic information. We will then call you back when your exam room is ready.
Please review the following questions prior to your appointment.

- Do you have any symptoms of illness (fever, cough, shortness of breath, loss of taste or smell, vomiting, or diarrhea)?
- Have you travelled outside of CT in the last 10 days?
- Have you come in contact with anyone with COVID?
- Have you had a COVID test and not yet know the results of the test?(must be PCR test-not Rapid)
- Have you tested positive for COVID and not yet cleared by your physician?

If you answered yes to any of the above questions please contact our office prior to your appointment, we may need to reschedule your appointment.

If you have any questions regarding your appointment, please call the office directly at 203-250-7577.

Thank you,

Cheshire Dermatology

Patient Registration Date:________________

Please Print Clearly

Last Name: ________________________ **First Name:** ________________________ **Middle Initial:**_____

Sex: ____ **Date of Birth:**___/___/_____ **Age:**______ **Social Security:**_____-______-______

Address:____

City: ______________________________ **State:**___________ **Zip Code**_______-______

Home Phone #: ________________**Work Phone #:**_________________**Cell Phone:**_________________

Circle preferred number: HOME WORK CELL

Email Address: ______________________________________

Please Circle Race: American Indian African American or Black Native

Native Hawaiian/Other Pacific White Other:__________________

Ethnicity: *Circle One*: Hispanic or Latino Not Hispanic or Latino

Primary Language: ____

Employer: ____**Occupation:** ______________________

INSURANCE

Primary Insurance: ____

ID #: ____ **Group #:** ___________________

Policy Holder's Name: _____________________________________**Relation:** _____________________

Policy Holder's SS#: ____-_____-_____ **Policy Holder's Date of Birth:** ___/____/____

Specialist Copay: _______________________

Secondary Insurance: ____

ID #: ______________________________________ **Group #:** __________________

Policy Holder's Name: _______________________________________ **Relation:** ____________________

Policy Holder's SS#: ____-_____-_____ **Policy Holder's Date of Birth:** ___/____/____

Specialist Copay: _______________________

Pharmacy and Referrals

Pharmacy Name, Street Address & Telephone #:____

Primary Care Physician's Name, Location & Telephone #:____

Patient Name: ________________________________ **Date of Birth:**________

Power of Attorney(POA)(If applicable, please provide copy):

Name: ______________________________ Phone:___________________

Relation:__________

Emergency Contact:

Name: ______________________________ Phone:____________________

Relation:__________

HIPAA ACKNOWLEDGEMENT:

I give permission to discuss any of my financial and medical issues with the following person/s.

Person/s Name: ________________________________ Relationship:___________

Phone Number:_________________________________

Patient Signature:____

I attest that my personal information and insurance information is accurate. Failure to provide accurate insurance information may result in reject claims.

I further attest that I have filled out the attached self-assessment medical questionnaire as completely as possible. I am wholly responsible for information that is omitted and hold the provider harmless for medical decisions made without this information.

____ __________________

Patient/Legal Guardian Signature DATE

Minor Patients only:

Guardian/Responsible Party: ____

Relation:__________

Birth Date____/____/_____ Social Security #_____-______-______

Tel#___________________

Address (If different from patient's):____

Reason for Today's Visit

Concern:____ Duration:____________

Prior Treatment:____

Concern:____ Duration:____________

Prior Treatment:____

Patient Name: ______________________________ **Date of Birth:** ____________

Medical History

CIRCLE YES/NO FOR ALL OF THE FOLLOWING AND SPECIFY IN SECTION BELOW

Anxiety	Yes	No
Arthritis	Yes	No
Asthma	Yes	No
Atrial Fibrillation	Yes	No
Bone Marrow Transplant	Yes	No
BPH	Yes	No
Breast Cancer	Yes	No
Colon Cancer	Yes	No
COPD	Yes	No
Coronary Artery Disease	Yes	No
Depression	Yes	No
Diabetes	Yes	No
End Stage Renal Disease	Yes	No
GERD	Yes	No
Hearing Loss	Yes	No
Hepatitis	Yes	No
Hypertension	Yes	No
HIV/AIDS	Yes	No
Hypercholesterolemia	Yes	No
Hyperthyroidism	Yes	No
Hypothyroidism	Yes	No
Leukemia	Yes	No
Lung Cancer	Yes	No
Lymphoma	Yes	No
Prostate Cancer	Yes	No
Radiation Treatment	Yes	No
S izures	Yes	No
CVA/Stroke	Yes	No
Congestive Heart Failure	Yes	No
Liver Disease- Hepatitis	Yes	No
Liver Disease- Hepatitis A	Yes	No
Liver Disease- Hepatitis B	Yes	No
Liver Disease- Hepatitis C	Yes	No
Parkinson's	Yes	No
Autoimmune Disorder	Yes	No
Lupus	Yes	No
Rheumatoid Arthritis	Yes	No
Peripheral artery disease	Yes	No
Scleroderma	Yes	No
Sjorgren's syndrome	Yes	No

OTHER: ______________________________

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Alerts(Circle yes or no)

Allergy to adhesive	Yes	No
Allergy to lidocaine	Yes	No
Artificial heart valve	Yes	No
Artificial Joints within last two years	Yes	No
Blood thinners	Yes	No
Defibrillator	Yes	No
MRSA	Yes	No
Pacemaker	Yes	No
Premedication prior to procedures	Yes	No
Rapid heartbeat with epinephrine	Yes	No

Allergies to medications (*Please list all known medication allergies as well as the type of reaction)*

Allergy: ______________________________ Reaction: ______________________

Allergy: ______________________________ Reaction: ______________________

Sensitivity to Epinephrine: Yes______ No_______ **Allergy to Latex:** Yes________ No________

Allergy to Betadine, Iodine, Shellfish, IV dye Yes_________ No_______

Patient Name:______________________________ **Date of Birth:**__________

Influenza Vaccine(FLU) Yes No If yes, when was the last time vaccine was received?____________
Pneumonia Vaccine: Yes No If yes, when was the last time vaccine was received?____________

Personal History of Skin Cancer: *(Basal Cell Carcinoma, Squamous Cell Carcinoma, Melanoma)*

Type: **Year:** **Treatment:**

____

____

Sun Exposure History:

Current Outdoor Occupation Yes:____ No:____ Number of Years:________

Former Outdoor Occupation Yes:____ No:____ Number of Years:________

History of Blistering Sunburns Yes:____ No:____ Approximate Number:________

Organ Transplant (specific Type):
Type:______________________________________**Year:**________________

Stem Cell Transplant: Yes:____ No:____

Are you taking Immunosuppressive Medications? Yes:____ No:____

Medications (*Please list all medications you are currently taking: (or attach medication list)*)

Drug:__________________________________ Dosage:________ Frequency:________

Drug:__________________________________ Dosage:________ Frequency:________

Drug:__________________________________ Dosage:________ Frequency:________

Drug:__________________________________ Dosage:________ Frequency:________

Drug:__________________________________ Dosage:________ Frequency:________

Drug:__________________________________ Dosage:________ Frequency:________

Drug:__________________________________ Dosage:________ Frequency:________

Female Patients Only
Please complete the following

Are you Pregnant Yes:____ No:____ Breastfeeding? Yes:____ No:____

Are you on birth control? Yes:____ No:____ Do you have regular menstrual cycles? Yes:____No:____

When was your last menstrual cycle? ______________

Minor Patients Only (18 or under):

Height:__________ Weight__________lbs

Patient Name:______________________________ **Date of Birth:**________

Social History

Smoking Status: Circle One

Never	Current Some Day Smoker	Cigar Smoker
Former Smoker	Current Every Day Smoker	Chewing Tobacco User

If applicable:

When did you start smoking:____________________ Number of packs per day:_______________

When did you quit smoking:____________________ Total Number of years smoking:__________

Alcohol Consumption: Circle one

None	1-2 Drinks per day	Other:________________
Less than 1 drink per day	3+ Drinks per Day	

Other Social History: Circle One

Not Sexually Active	Drug Use
Sexually Active with one partner	IV Drug Use
Sexually Active with multiple partners	

Family History

Please list any family history of illness or disease:

Disease/ Illness :___________________________ Relation:________________ Deceased? Yes No

Disease/ Illness :___________________________ Relation:________________ Deceased? Yes No

Family History of Skin Cancer:

Type:	**Family Member and approximate age of diagnosis:**
Basal Cell Carcinoma:____________________	____________________________________
Squamous Cell Carcinoma:____________________	____________________________________
Melanoma: ______________________________	____________________________________

Additional Symptoms

Circle Yes/No

Problems with bleeding	Yes/No	Problems with healing	Yes/No	Problems with scarring	Yes/No
Rash	Yes/No	Immunosuppression	Yes/No	Hay Fever	Yes/No
Chest Pain	Yes/No	Fever and Chills	Yes/No	Night sweats	Yes/No
Unintended weight loss	Yes/No	Thyroid Problems	Yes/No	Sore Throat	Yes/No
Abdominal Pain	Yes/No	Bloody Stool	Yes/No	Bloody Urine	Yes/No
Muscle Weakness	Yes/No	Neck Stiffness	Yes/No	Headaches	Yes/No
Seizures	Yes/No	Cough	Yes/No	Shortness of Breath	Yes/No
Wheezing	Yes/No	Anxiety	Yes/No	Depression	Yes/No
Blurry Vision	Yes/No	Joint Aches	Yes/No		