LUX DERMATOLOGY

PLEASE PRINT LEGIBLY **ALL (*) ITEMS ARE REQUIRED**

PATIENT INFORMATION

Prefix: _____ ***Last Name**: _____ ***First Name**: _____

Middle Name: _____ Suffix: _____ Nickname: _____

Marital Status: _____ ***Social Security Number:** _____

***Date of Birth**: _____ City of Birth: _____ ***Birth Sex**: M / F

Language Spoken: _____ Ethnic Group: _____ Race: _____

Street Address: _____ Address Line 2: _____

City: _____ State: _____ Zip: _____ Country: _____

Employer's Name: _____ Occupation: _____

Employment Status: FULL-TIME PART-TIME RETIRED DISABLED STUDENT UNEMPLOYED

Preferred Phone Number (Circle One): HOME WORK MOBILE

Home #: _____ Work #: _____ Mobile #: _____

***Is it OK to leave a detailed message:** **YES** **NO**

Email: _____ Alternate Email: _____

***Would you like to opt into email notification:** **YES** **NO**

***Emergency Contact Name:** _____ ***Phone Number:** _____

Spouse Full Name: _____ Phone Number: _____

Caretaker Full Name: _____ Phone Number: _____

GUARDIAN INFORMATION (Under 18 ONLY)

Mother's Name: _____ Phone Number: _____

Father's Name: _____ Phone Number: _____

Guardian's Name: _____ Phone Number: _____

INSURANCE INFORMATION

Plan Name: _____ ***Policy Type:** _____

***Policy Number:** _____ Group Number: _____

Name on Insurance Card Last Name:_____ First Name: _____

Policy Holder Relationship: **SELF** **SPOUSE** **CHILD** **OTHER**

Does your insurance have a preferred Laboratory? NO YES If Yes Laboratory Name: _____

RESPONSIBLE PARTY

***Relationship to Patient (Circle One):** **SELF** **SPOUSE** **CHILD** **OTHER**

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

Prefix: _____ ***Date of Birth:** _____ Social Security Number: _____

***Street Address:** _____Address Line 2: _____

***City:** _____ ***State:** _____ ***Zip:** _____ ***Country:** _____

Home #: _____ Work #: _____ Mobile #: _____

Email: _____ Alternate Email: _____

RELEASE OF PERSONAL RECORDS

I, _____hereby give my permission to Lux Dermatology to release any information pertaining to me to the following:

Full Name: _____ Relationship to Pt: _____

Home Number: _____ Mobile Number: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

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PAST MEDICAL CONDITIONS (Circle All that Apply)

ARTHRITIS	CHRONIC OBSTRUCTIVE LUNG DISEASE	DEPRESSIVE DISORDER
DIABETES MELLITUS	END-STAGE RENAL DISEASE	HISTORY OF HYPERTENSION
H.I.V.	HYPERCHOLESTEROLEMIA	LEUKEMIA
MALIGNANT LYMPHOMA	MALIGNANT TUMOR OF THE COLON	HEARING LOSS

LAST MENSTRUAL DATE: _____

PAST SURGERIES (Circle All that Apply)

HISTORY OF COLECTOMY	KIDNEY TRANSPLANT	EXCISION OF MELANOMA	HEART TRANSPLANT
JOINT REPLACEMENT	LIVER TRANSPLANT	MECHANICAL HEART VALVE REPLACEMENT	

OTHER: _____

SKIN CONDITIONS (Circle All that Apply)

ACNE	ACTINIC KERATOSIS	BASAL CELL CARCINOMA OF SKIN
DYSPLASTIC NEVUS OF SKIN	ECZEMA	FAMILY HISTORY OF MELANOMA
HISTORY OF ASTHMA	MALIGNANT MELANOMA	PSORIASIS
SQUAMOUS CELL CARCINOMA	SUNBURN OF SECOND-DEGREE	SUN PROTECTION SPF: _____

ALLERGIES (Please list all allergies & types of reactions)

_____

_____

_____

_____

_____

5333 Hollister Avenue, Suite 105, Santa Barbara, CA 93111-3309, www.luxdermatologists.com
Phone: (805) 770-8400 Fax: (805) 770-8402

MIPS Patient Intake Form

Name: _____ DOB: _____ Email: _____

Primary Care Physician: _____ Referring Physician: _____

Melanoma:

Have you ever been diagnosed with Melanoma? ☐ Yes ☐ No

If YES, did you ever have a chest X-ray, CT, Ultrasound, MRI, or PET? ☐ Yes ☐ No

Alcohol Use:

How often do you have an alcoholic beverage?

☐ Never ☐ Less than one drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day

Tobacco Use: (Please choose the option that best describes tobacco use)

☐ Never ☐ Current everyday smoker ☐ Current some day smoker ☐ Former Smoker

Current Smokers: ☐ 1-3 cigarettes per day ☐ Up to 1 pack per day

☐ 1-2 packs per day ☐ 2 or more packs per day

Current Medications: (Include Name, Dosage, Frequency, & How it is Taken)

_____

_____

_____

_____

_____

_____

Immunizations: Have you received the following vaccinations?

Flu Vaccine (during the last flu season): ☐ Yes ☐ No

Pneumonia Vaccine: ☐ Yes ☐ No

66 years & Over: Do you have the following:

☐ Power of Attorney (Surrogate Decision Maker) ☐ Living Will ☐ None

Name/Relationship:_____ (Advance Care Plan)