



**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: \_\_\_\_\_



**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)**

---

---

---

---

---



## 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)