

PATIENT INFORMATION QUESTIONNAIRE

DATE COMPLETED: _____

Please provide the information requested below. This becomes part of your records and remains strictly confidential.

PLEASE PRINT!

NAME: _____

ADDRESS: (LOCAL) _____

CITY/STATE/ZIP: _____

ADDRESS: (PERMANENT) _____ EMAIL ADDRESS: _____

HOME PHONE#: _____ WORK PHONE# _____ CELL# _____

AGE: _____ DOB: _____ HEIGHT: _____ WEIGHT: _____ EYE COLOR: _____

SOCIAL SECURITY# _____ OCCUPATION: _____

EMPLOYER: _____

SPOUSE/PARENT/GUARDIAN: _____

FAMILY PHYSICIAN/PCP: _____ TELEPHONE #: _____

NAME OF PERSON WHO REFERRED YOU HERE: _____

INSURANCE INFORMATION

MEDICARE#: _____

OTHER INSURANCE: _____ ID#: _____ GRP#: _____

MEDICAL INFORMATION

ALLERGIES: _____

CURRENT MEDICATIONS (RX & OTC): _____

CURRENT SKIN PROBLEM: _____

PAST SKIN PROBLEMS: _____

POSSIBILITY OF CURRENT PREGNANCY? YES NO

CURRENT OR PAST MEDICAL CONDIITONS (CHECK APPLICABLE):

___ DIABETES ___ HEART DISORDER ___ HYPERTENSION ___ LUNG DISORDER

___ STROKE ___ KIDNEY DISORDER ___ THYROID DISORDER ___ INTESTINAL DISORDER

___ BLOOD DISORDER ___ OTHER? _____

HISTORY OF KELOIDS? YES NO HISTORY OF WOUND HEALING?: GOOD FAIR SLOW POOR

DO YOU HAVE A HISTORY OF MELANOMA OR OTHER SKIN CANCER IN YOUR FAMILY? YES NO

*PATIENT IS REponsible FOR ALL PROFESSIONAL SERVICE FEES, REGARDLESS OF INSURANCE COVERAGE. *PAYMENT IS EXPECTED AT THE TIME OF SERVICE UNLESS ARRANGEMENTS ARE MADE IN ADVANCE. *FOLLOW UP APPOINTMENTS MISSED WITHOUT NOTICE ARE SUBJECT TO NORMAL FOLLOW-UP FEE *SERVICES PERFORMED AT LABORATORIES OUTSIDE THIS OFFICE WILL BE BILLED TO THE PATIENT DIRECTLY AND ARE NOT INCLUDED IN DR. ROPER'S FEE.

YOUR SIGNATURE: _____ (AUTHORIZATION FOR TREATMENT)

***You will be required to complete this form annually.

