Johnston Office
1539 Atwood Ave, Suite 301
Johnston, RI 02919
Phone: 401-490-4515 **Fax:** 401-217-2942

Coastal Dermatology and cosmetic center

Cranston Office
750 Reservoir Ave
Cranston, RI 02910
Phone: 401-943-0761 **Fax:** 401-217-2942

Patient Registration Form

Welcome! Thank you for choosing Coastal Dermatology & Cosmetic Center.
Please completely fill out this form to ensure the fastest and best healthcare service.

Patient Name: _____ Birthdate: _____/_____/_____ Preferred Language: _____

Sex: M_____ F_____ Gender Identity: M_____ F_____ Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Decline to answer [ ] Other_____

Race: [ ]Caucasian [ ]Hispanic or Latino [ ]African American [ ]American Indian [ ]Alaskan Native [ ]Asian [ ]Decline to answer [ ]Other

Home Address: _____City: _____ State: _____ Zip: _____

Telephone: Home: _____ Cell:_____ Email: _____

Do you give the office permission to call and/or leave messages on your phone numbers listed above: [ ] Yes [ ] No

Employer: _____ Occupation: _____

Primary Physician: _____ Phone #: _____Fax #: _____

Referring Physician: _____ Phone #: _____Fax #: _____

Pharmacy: _____ Pharmacy Phone: _____

Pharmacy Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____Phone #: _____

Insurance Information:

Primary Insurance: _____ Secondary Insurance: _____

Subscriber's Name: _____ DOB:_____ Subscriber's Name: _____ DOB:_____

By signing below, I hereby authorize Coastal Dermatology & Cosmetic Center to disclose my Protected Health Information to the following family members, friends or representatives.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient/Legal Guardian Signature: _____ Date: _____

I consent to treatment necessary for care of the above named patient. I authorized the release of all medical records to the referring family physician and to my insurance company. If applicable, I allow fax transmittal of my medical records. If necessary, I acknowledge full financial responsibility for services rendered by Coastal Dermatology & Cosmetic Center, Inc. If my insurance does not pay for all or part of the services rendered to me by physician I understand that I am fully responsible for payment of all services. I understand that full payment/co-payment are due at the time of service unless other definite financial arrangements have been made prior to treatment. I future authorize and request that insurance payments be made directly to Coastal Dermatology & Cosmetic Center, Inc. should they elect to receive such payments. I have read and fully understand the above consent of treatment, financial responsibility and insurance authorization.

Patient/Legal Guardian Signature: _____ Date: _____

I consent to give my permission for photography to be used for comparison of the treatment results and medical records.

Patient/Legal Guardian Signature: _____ Date: _____

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What is the primary reason for your visit today?

☐ Full Skin Exam ☐ Rash ☐ Changing Mole ☐ Acne ☐ Psoriasis
☐ Warts ☐ Cosmetic Consult ☐ Other_____

Current medications:

Medication	Dose	How often	Medication	Dose	How often

Do you give consent for Coastal Dermatology to import your medication list from your pharmacy? ☐ ***Yes*** ☐ ***No***

Allergies: _____ ☐ No known allergies

Past Medical History: (please circle all that apply)

None Anxiety Arthritis
Artificial joints Asthma Atrial fibrillation
COPD BPH (Benign Prostate Hyperplasia) Bone Marrow Transplantation
Cancer: Type_____ Coronary Artery Disease Depression
Diabetes End Stage Renal Disease GERD (Acid reflux)
Hearing Loss Hepatitis Hypertension
HIV/AIDS Hypercholesterolemia Seizures
Hyperthyroidism Hypothyroidism Stroke
Leukemia Lymphoma Other: _____

Past Surgeries: **(please circle all that apply)**

None Appendix Removed Bladder Removed
Gallbladder Removed Prostate Removed Prostate Biopsy
Testicles Removed Skin Cancer Surgery Spleen Removed
Pancreas Removed Coronary Artery Bypass Valve Replacement
Lumpectomy (Right/Left/Both) Breast Biopsy (Right/Left/Both) Mastectomy (Right/Left/Both)
Kidney Removed (Right/ Left) Kidney Stone Removal Organ Transplant: _____
Knee Replacement (Right/ Left/ Both) Hip Replacement (Right/ Left/ Both)
Hysterectomy: Fibroids/ Uterine Cancer/ Other Ovaries Removed: Endometriosis/ Cyst/ Cancer/ Other
Colectomy: Colon Cancer Resection/ IBD/ Other Other: _____

Skin Disease History: **(please circle all that apply)**

None Acne Actinic Keratoses Blistering Sunburns
Dry Skin Eczema Hay Fever/Allergies Psoriasis
Precancerous Moles Basal Cell Skin Cancer Squamous Cell Skin Cancer Melanoma
Flaking or Itchy Scalp Other: _____

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Family History:

□ Melanoma. Relatives: _____

□ Basal Cell Carcinoma. Relatives: _____

□ Squamous Cell Carcinoma. Relatives: _____

□ Hay Fever/Allergies. Relatives: _____

□ Precancerous Moles. Relatives: _____

□ Psoriasis. Relatives: _____

□ Other (please specify) _____

Please check YES or NO to each of the following as they apply to you at TODAY'S VISIT

SYMPTOM	YES	NO	SYMPTOM	YES	NO
Problems with Bleeding			Neck stiffness		
Problems with Healing/ Scarring			Headaches		
Immunosuppression			Joint aches		
Rash			Wheezing		
Hay fever			Allergy to topical Antibiotic		
Chest pain			MRSA		
Fever or chills			On Blood Thinners		
Night sweats			Defibrillator		
Unintentional weight loss			Pacemaker		
Thyroid problems			Artificial Heart Valve		
Sore throat			Artificial Joint within past 2 years		
Blurry vision			Premedication prior to procedures		
Nausea/ Vomiting/ Diarrhea			Pregnancy or planning pregnancy		
Abdominal pain			Allergy to Adhesive		
Bloody stool or bloody urine			Allergy to Lidocaine		
Muscle weakness			Allergy to Epinephrine		

Do you have any of the following symptoms today? □ None

□ Flu-Like symptoms □ Fever □ Cough □Fatigue □Body aches □ Shortness of breath

In the two weeks, have you traveled domestically or internationally? □ No □ Yes

If yes, where: _____

Tobacco:

□ Never Smoker □ Current Smoker □ Former Smoker

Alcohol:

□ No Alcohol □ Less than 1 drink/day □ 1-2 drinks/ day □ 3 or more drinks/day

Immunizations:

Did you receive the Influenza vaccine during the last flu season? □ YES □ NO

Have you received the COVID-19 Vaccine? □ YES □ NO

Certification of patient information:

I certify that all information provided on this date to Coastal Dermatology & Cosmetic Center is correct.

Signature: _____**Date**: _____