Processor Initials _____

STOCKTON DERMATOLOGY

TONI C. STOCKTON, MD, FAAD, PLLC
16611 S. 40th Street, Suite 100, Phoenix, Arizona 85048 480.610.6366 www.StocktonDermatology.com

PATIENT REGISTRATION

Date: _____ Please circle: **NEW** or **UPDATED** ****Please PRINT and COMPLETE using BLACK INK only****

LAST Name: _____ **FIRST** Name: _____ Middle Initial: ___ DOB: _____ Age: _____ Sex: ____

Race: _____ SSN: _____ - _____ - _____ Marital Status: Married / Divorced / Widowed / Single

Address: _____ City: _____ State: _____ ZIP: _____

Alternate Address: _____ City: _____ State: _____ ZIP: _____

Primary Phone for Contact: (_____) _____ - _____ Cell/Other Phone: (_____) _____ - _____

Emergency Contact Name: _____ Emergency Contact Phone: (_____) _____ - _____

Email Address: _____ Occupation: _____

****

Primary Care Physician: _____ Primary Care Physician Phone: (_____) _____ - _____

Referring Physician: _____ Referring Physician Phone: (_____) _____ - _____

Preferred Pharmacy: _____ Pharmacy Phone Number (_____) _____ - _____

Dermatology Brand-Name medications are often more effective than Generic medications.

Do you prefer? Brand-Name Usually Generic Meds if Equally Effective Generic Meds Even if Less Effective to Save Cost

Primary Insurance Company: _____ Policy Holder Name: _____

Relationship to Patient: _____ Policy Holder SSN: _____ - _____ - _____ DOB: _____ / _____ / ____

Insurance ID# _____ Employer: _____

Secondary Insurance Company: _____ Policy Holder Name: _____

Relationship to Patient: _____ Policy Holder SSN: _____ - _____ - _____ DOB: _____ / _____ / _____

Insurance ID#: _____ Employer: _____

PLEASE NOTE: All required referrals must be coordinated by the PCP and faxed prior to or presented at the time of the appointment

****

Health Portability and Accountability Act of 1996 (HIPAA) also includes protected health information.

Signing below signifies that you have had the opportunity to view and/or receive explanation of the privacy notice. You may request a copy or read a copy located in the waiting room.

Printed Name _____ Patient Signature _____ Date _____

Witness _____ Date _____

You authorize sharing of your Personal Health Information (PHI) with someone else? No Yes *If Yes, who? _____

Aesthetic services and cosmetic procedures that our office provides:
•Restylane® •Juvederm® •Botox® •Intense Pulsed Light •Spider Vein Therapy •Facials •Chemical Peels •Microdermabrasion •Procedures for Wrinkles, Sun Damage, Skin Tightening, Dark Spots, Unwanted Hair or Acne
Would you like to schedule a consultation with an aesthetician at a later date? Yes No
Would you like to receive email notifications regarding monthly treatment and skin care specials? Yes No

How did you hear about Stockton Dermatology?
____ Friend ____ Facebook ____ Twitter ____Our Website ____Newspaper ____ Yellow Pages ____Other _____

**********FOR OFFICE USE ONLY BELOW********FOR OFFICE USE ONLY BELOW**********

MR #: _____ Provider _____

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PATIENT MEDICAL HISTORY

Date: _____ Please circle: **NEW** or **UPDATED** ****Please PRINT and COMPLETE using BLACK INK only****

LAST Name: _____ **FIRST** Name: _____ Middle Initial: ___ DOB: _____ Male Female

Are you allergic to any medications? No Yes Aspirin Codeine Erythromycin Penicillin Sulfa Other _____

Current **Oral / Topical / Injectable Medications / None**

_____ _____ _____

Do you use any **natural, herbal or alternative medicine** products? No Yes please list _____
What is the **MAIN REASON** for your visit today? _____
Where is the location of the problem? _____ **When** did this current episode begin? _____
How long have you had this problem? Days Weeks Months Years Unknown Off and On for Years
Have you had **previous treatment** for this condition in the past? No Yes
Over-the-Counter _____ Rx Oral Meds _____ Rx Long-Term Meds _____
Rx Topical Meds _____ Surgery Light Therapy Laser Biopsies Blood Work
Did the treatment help? No Yes
If it is a skin lesion, is the **lesion changing** in **Color Size Shape**? _____ **Slowly** or **Rapidly?**

Skin History Do you **now** or have you in the **past** had any skin related problems? None
Abnormal Scars/ Keloids Cold Sores Herpes I or II Bleeding Disorders Slow Wound Healing Accutane Use
Acne Rosacea Folliculitis Boils Hives Dermatitis/Skin Rashes/Eczema Psoriasis Contact Dermatitis
Pre-cancerous Lesions Abnormal Moles (Dysplastic Nevi)
Skin Cancer Type and Location Please Circle Below and Write Location How Long Ago? _____
Basal Cell Carcinoma _____ **Squamous** Cell Carcinoma _____ Melanoma _____

Social History
Do you smoke? No Yes Do you use any recreational or IV drugs? No Yes If Yes, what? _____
Do you drink alcohol? No Yes If Yes, how many drinks, daily? _____ weekly? _____
For women, are you pregnant? No Yes If Yes, due date? _____ Are you breastfeeding? No Yes
What is your occupation? _____
Have you ever used a tanning booth? No Yes Are you exposed to the sun excessively? No Yes
Do you have any other MAJOR medical problems? No Yes What? _____
Do you require antibiotics prior to surgical procedures? No Yes Why? Artificial Joint or Valve or Murmur

PAST MEDICAL HISTORY do you **now** or in the **past** have a **history** of any of the following?

Allergy/Immunology	None	Allergy Shots Fibromyalgia HIV Positive Lupus Other _____
Blood / Lymph	None	Anemia Easy Bruising Transfusion Leukemia/Lymphoma (type) _____ Bleeding Disorder Low Platelets Blood Clot Issue Hemophilia Other _____
Bowel / Stomach	None	Colon Cancer Hepatitis A Hepatitis B Hepatitis C Liver Problems Ulcers
Ear, Nose, Throat	None	Fever Blisters Permanent Lip Makeup Sinus Problems Other _____
Eyes	None	Conjunctivitis Dry Eyes Glaucoma Permanent Eye Makeup Other _____
General	None	Dizziness/Vertigo Fatigue Psychiatric Concerns Weight Change Other _____
Genital / Urinary	None	Bladder Problems Herpes Kidney Problems Genital Rash Irregular Menses Polycystic Ovarian Disease Fibroids Recently Stop/Start Hormone Therapy Other _____
Heart / Circulation	None	Artificial Valve Chest Pain High Blood Pressure Irregular Heart Beat Murmur Leg Ulcers Pacemaker Varicose Veins Other _____
Hormones	None	Diabetes Pituitary Problems Thyroid Problems Other _____
Lung	None	Asthma Sarcoidosis Tuberculosis Valley Fever Other _____
Muscle / Bone	None	Arthritis Artificial Joint Joint Swelling Weakness Other _____
Nerve / Neurological	None	Lou Gehrig's(ALS) Migraine Multiple Sclerosis Seizure Stroke Other _____
Skin	None	Yes _____
Surgeries	None	Skin Cancer(s) _____ Transplant (type) _____ Other _____
Family History	None	Acne Atypical Moles (Dysplastic Nevi) Arthritis Diabetes Eczema Heart Lupus Psoriasis Sarcoid Thyroid Other _____ Skin Cancer Basal Cell Carcinoma Lymphoma Melanoma Squamous Cell Carcinoma

**********FOR OFFICE USE ONLY BELOW**********FOR OFFICE USE ONLY BELOW**********

Medical History Form Completed by Patient _____ other _____ and reviewed for completion by _____ B/O Dated _____

REV.TCS 06/2021

Provider _____ Ok to Scan