Chatham Dermatology

Today's Date________________

Due to new requirements from the United States Department of Health and Human Services, we are requesting that all patients complete our Supplemental Patient Intake Form. We realize that some of the questions may be redundant. We appreciate your patience and apologize for any inconvenience.

Patient's Name (PRINT)______________________________ Social Security#_________________

Date of Birth: _____/_____/_____ Sex: M □ F □ Patient Phone Number_________________

We are in the process of implementing a Patient Portal ro provide a communication option for our patients in compliance with Health and Human Service Requirements. Please provide a valid email address below:

(REQUIRED)__________________________________@____________________

Family History of Skin Cancer? □None □Mother □Father □Sister □Brother

Smoking Status:
- □ Never smoked
- □ Former Smoker
- □ Current every day smoker
- □ Heavy tobacco smoker
- □ Light tobacco smoker

Do you take any prescription medications?

□ No □Yes (if yes please list)____

____Dosage______________________________

____Dosage______________________________

____Dosage______________________________

____Dosage______________________________

Pharmacy Name?_____________________________Phone Number?________________________

Allergies to Medications?

Reaction____
____

Signature:____
(Parent or Guardian Signature if child is a minor)