Kālia
Dermatology & Laser Center, Inc.

Patient Registration Form

Last Name: _____ **First Name:** _____

Address: _____ **City:** _____ **ZipCode:** _____

Date of Birth: _____ / _____ / _____ **Sex:** Female / Male (circle one)

Home Phone: _____-_____-_____ ***Cell Phone:** _____-_____-_____

***PREFFERED phone number: Cell:_____ Home:_____ (check one)

Employer Name: _____ **Marital Status:** _____

Occupation: _____

***Does our office have permission to leave a detailed message? Yes:_____ No:_____ (check one)

Primary Care Physician: _____

***Email Address:**

How did you hear about us? (choose one) **Patient or Doctor Referral**: _____
___Yelp ___ Google Search ___ NBC ___ San Jose Mercury News ___ Yellow Pages
___ Insurance Network Directory ___ Facebook ___ other: _____

PHARMACY: Name / Location: _____ **Phone:** _____-_____-_____

***EMERGENCY CONTACT:**
Last Name: _____ **First Name:** _____
Contact's Phone: _____-_____-_____ **Relationship to patient:** _____

Primary Insurance: **Please enter name exactly as it appears on the insurance card:**
Insurance Company: _____
***Policyholder's name (Required):** _____
***Policyholder's date of birth:** _____/_____/_____

Relationship to Patient: (circle one) self spouse parent other_____

PATIENT SIGNATURE: _____ **Date:** _____

Parent Signature ***if patient is under 18 years of age*:** _____

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History and Intake Form

First Name:_____ **Last Name:**_____ **Date:**_____

Reason(s) for today's visit:_____

Medical History: (Please check all that apply or check NONE)

- ❑ NONE
- ❑ Accutane/anticoagulants within the last 6 months.
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial fibrillation
- ❑ Bone Marrow Transplantation
- ❑ BPH
- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ COPD
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes
- ❑ End Stage Renal Disease
- ❑ GERD
- ❑ Hearing Loss
- ❑ Hepatitis
- ❑ Hypertension
- ❑ HIV/AIDS
- ❑ High Cholesterol
- ❑ Hyperthyroid
- ❑ Hypothyroid
- ❑ Leukemia
- ❑ Lung Cancer
- ❑ Lymphoma
- ❑ Prostate Cancer
- ❑ Radiation Treatment
- ❑ Seizures
- ❑ Stroke
- ❑ Pacemaker
- ❑ Use of Minocyclines, Tetracycline, Vitamin E, or St. John's Wort, all which have been known to induce photo sensitivity to light exposure at the wavelengths used with IR (InfraRed)
- ❑ Other _____

_____

***Have you had your flu shot this year? Yes:_____ No:_____ (check one)

Past Surgical History: (Please check all that apply or check NONE)

- ❑ NONE
- ❑ Appendix Removed
- ❑ Bladder Removed
- ❑ Breast Biopsy (Right, Left)
- ❑ Breast: Lumpectomy (Right, Left)
- ❑ Breast: Mastectomy (Right, Left)
- ❑ Colectomy: Colon Cancer Resection
- ❑ Colectomy: Diverticulitis
- ❑ Colectomy: Inflammatory Bowel Disease
- ❑ Colon: Colostomy
- ❑ Gallbladder Removed
- ❑ Biological Valve Replacement
- ❑ Coronary Artery Bypass Surgery
- ❑ Heart Transplant
- ❑ Mechanical Valve Replacement
- ❑ Heart: PTCA
- ❑ Joint Replacement - Knee (Right, Left)
- ❑ Joint Replacement - Hip (Right, Left)
- ❑ Joint Replacement within last 2 years
- ❑ Kidney Biopsy (Nephrectomy)
- ❑ Kidney Removed (Right, Left)
- ❑ Kidney Stone Removal
- ❑ Kidney Transplant
- ❑ Liver: Hepatectomy
- ❑ Liver: Liver Transplant
- ❑ Liver: Shunt
- ❑ Ovaries Removed: Endometriosis
- ❑ Ovaries Removed: Cyst
- ❑ Ovaries Removed: Ovarian Cancer
- ❑ Pancreas Removed
- ❑ Prostate Cancer
- ❑ Prostate Biopsy
- ❑ TURP (Prostate Removal)
- ❑ Rectum APR
- ❑ Rectum Low Anterior Resection
- ❑ Spleen Removed
- ❑ Superficial metal or other implants
- ❑ Testicles Removed (Right, Left)
- ❑ Hysterectomy: Fibroids
- ❑ Hysterectomy: Uterine Cancer
- ❑ Hysterectomy: Cervical Cancer
- ❑ Recent Permanent Makeup / tattoos, location:_____

_____

- ❑ Other _____

_____

Skin Disease History: (Please check all that apply or check NONE)

- ❑ NONE
- ❑ Acne
- ❑ Actinic Keratoses
- ❑ Basal Cell Skin Cancer
- ❑ Blistering Sunburns
- ❑ Dry Skin
- ❑ Eczema
- ❑ Flaking or Itchy Scalp
- ❑ Hay Fever/Allergies
- ❑ Herpes Labialis / Cold Sores
- ❑ Herpes Simplex or Shingles
- ❑ Keloids
- ❑ Melanoma
- ❑ Poison Ivy
- ❑ Atypical Moles
- ❑ Psoriasis
- ❑ Squamous Cell Skin Cancer
- ❑ Other _____

Do you wear Sunscreen? (Please circle one) Yes No
If yes, what SPF? _____

Do you tan in a tanning salon? (Please circle one) Yes No

Do you have a family history of Melanoma? (Please circle one) Yes No
If yes, which relative? _____

Medications: (Please enter all current medications) NONE

_____
_____
_____
_____

Allergies: (Please enter all allergies) NONE

_____
_____
_____
_____

Social History: (Federal guidelines require us to ask these questions. Answering is optional)

Cigarette Smoking: (Please check one)
- ❑ Smokes Less Than Daily
- ❑ Smokes Daily
- ❑ Never Smoked
- ❑ Quit: Former Smoker

Alcohol Intake: (Please check one)
- ❑ None
- ❑ Less than 1 drink per day
- ❑ 1-2 drinks per day
- ❑ 3 or more drinks per day

65 Years or Older:
How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women?
_____

For Women: (Please circle all that apply)
Pregnant - Yes/No Nursing - Yes/No Hormone Replacement Therapy – Yes/No

Medical Conditions That Run In The Family: (Including skin cancer)

_____
_____
_____