COASTAL DERMATOLOGY, PA

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PATIENT NAME:_____

DOB_____ PHONE NUMBER_____

EMAIL ADDRESS_____

PHARMACY_____

PRIMARY CARE PHYSICIAN:_____

REFERRED BY:_____

APPROXIMATE WEIGHT_____ HEIGHT_____

ARE YOU EXPERIENCING ANY COVID-19 SYMPTOMS_____

HAVE YOU BEEN TESTED IN THE LAST 14 DAYS FOR COVID-19_____

IF YES DATE AND WHAT WERE RESULTS _____

HAVE YOU TRAVELED OUTSIDE THE STATE OR COUNTRY IN
THE LAST 14 DAYS_____

HAVE YOU HAD A FLU VACCINE THIS YEAR_____

HAVE YOU HAD A PNEUMOCOCCAL VACCINE THIS YEAR_____

HAVE YOU HAD A SHINGRIX VACCINE THIS YEAR_____

PLEASE CIRCLE ONE **CURRENT SMOKER** **FORMER SMOKER** **NON SMOKER**

DO YOU DRINK ALCOHOL_____HOW OFTEN_____

HOW MANY TIMES IN THE LAST YEAR HAVE YOU HAD 5 OR MORE DRINKS IN 1 SITTING_____

DO YOU HAVE AN ADVANCE DIRECTIVE CARE PLAN _____YES OR NO

WE REQUIRE 24 HRS NOTICE TO CANCEL OR RESCHEDULE AN APPOINTMENT AND IF YOU NO SHOW AN APPOINTMENT THERE IS A FEE OF $30 EXAM & $65 FOR COSMETIC OR SURGERY APPOINTMENTS PLEASE SIGN THAT YOU ACKNOWLEDGE OUR CANCELATION POLICY

SIGNATURE_____DATE_____