David A. Dasher, M.D.

ALAMANCE DERMATOLOGY

Arin L. Isenstein, M.D.

480 W. Webb Ave, Burlington, NC 27217
336-226-8000

Patient Information

Date: _____ Social Security Number: ____-___-_____

Patient Name: _____ Age:_____ DOB: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Gender: ☐M ☐F Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Preferred Language:_____ Ethnicity: ☐ Hispanic ☐ Latino ☐ N/A Race: _____

Mailing Address: _____

City:_____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Email: _____

List people that we may discuss your medical information with:

Name: _____ Relationship:_____ Phone:_____

Name: _____ Relationship:_____ Phone:_____

Name: _____ Relationship:_____ Phone:_____

Insurance Information

It is the patient's responsibility to provide our office with current insurance information (and referral if required) prior to being treated.

If your insurance is through a spouse or parent, please provide the following:

Name of Insured:_____ Insured's DOB_____

Insured's Social Security #: _____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

By signing below, I authorize payment of insurance benefits for any unpaid professional charges directly to Alamance Dermatology. I understand that I am responsible for any amount not covered by my insurance. I authorize treatment by Dr. David Dasher and Dr. Arin Isenstein for the duration of this physician/patient relationship.

_____ _____

Patient Signature
(Guardian must sign if patient is under 18)

Patient Printed Name

Date:_____

Patient Medical History (Circle all that apply)

Anemia
Arthritis
Artificial joints
Atrial Fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
Hepatitis
High Blood Pressure
HIV/AIDS
Inflammatory Bowel Disease
Lung Cancer
Lymphoma/Leukemia
Pacemaker
Prostate Cancer
Radiation Treatment
Stroke
Thyroid Disease
Valve Replacement
None

Other: _____

Past Surgical History (Circle all that apply)

Mastectomy
Lumpectomy
Colon Cancer Resection
Coronary Artery Bypass
Hysterectomy
None

Organ transplant: _____

Joint replacement: _____

Other: _____

Skin Disease History (Circle all that apply)

Atypical Moles
Basal Cell Skin Cancer
Blistering Sunburns
Eczema
Melanoma
Squamous Cell Skin Cancer

Other: _____

Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have a parent, sibling, or child with a history of Melanoma? ☐ Yes ☐ No

If yes, which relative(s)? _____

Medications: (Please enter all current medications)

_____

_____

_____

Allergies: (Please enter all allergies)

_____

_____

_____

Cigarette Smoking: ☐ Never ☐ Former Smoker ☐ Smokes less than daily ☐ Smokes daily

Which pharmacy do you use? _____ **Location or Phone #:** _____