WE CHARGE A NO-SHOW FEE OF $50.00 FOR ANY NO-SHOW OR CANCELLATION LESS THAN 24 HOURS

Snake River
DERMATOLOGY

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REASON FOR VISIT: _____

Patient: Last Name:_____First Name:_____MI:_____ DOB:__/__/___

Full address:_____City:_____State:____Zip:_____

Phone: (_____) _____ (*Texts?* Y/N) EMAIL* _____

SS#:_____ Gender: M/F Marital Status:_____

Responsible party: Last Name:_____First Name:_____MI:_____ DOB:__/__/___

Full address:_____City:_____State:____Zip:_____

Phone: (_____) _____ (*Texts?* Y/N) EMAIL* _____

SS#:_____ Gender: M/F Relationship to patient:_____

*By providing my email address I give permission to send me appointment reminders, patient information, and emails about specials and events. I understand I may unsubscribe any time, and that you will never sell or share my email with any external entity. *Check here if you do not want to receive promotional emails.* [ ]

Insurance Subscriber: Name_____Relationship to patient:_____DOB:__/__/__

Preferred pharmacy (name/location): _____Primary care provider_____

Medications(*with dosage*):_____

_____

Allergies to Medications: _____

Sunscreen use ☐ Tanning bed use ☐ Family history of melanoma ☐ Pregnant or trying ☐

Current/former smoker ☐ Do you drink alcohol (*how much*):_____

Major skin problems (*e.g. psoriasis, skin cancer*):_____

Major medical history (*e.g. diabetes, COPD*):_____

Major surgery (*e.g. organ transplant*):_____

Would you like to discuss treatment for (circle):

**acne scars *anti-aging *fine lines/wrinkles *unwanted hair *unwanted fat *dark/sun spots *stretch marks *spider veins *cellulite *uneven skin tone *uneven skin texture *lengthening eyelashes *sun protection *excessive sweating*

Do we have permission to: Leave message on your answering machine? ☐ Call/Leave a message at your work? ☐ Send reminder card? ☐ Discuss your medical condition with a household member? ☐
If yes, whom(full name)?_____Relationship_____

Signature (patient or responsible party)_____Date_____

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