GALVESTON DERMATOLOGY, P.A.
RAMON L. SANCHEZ, M.D.
DIPLOMATE AMERICAN BOARDS OF DERMATOLOGY AND DERMATOPATHOLOGY

Date:_____

Patient Full Name:_____Phone:_____
Mailing Address:_____
Street or PO Box Apt. City Zip

Social Security:_____Birthday:_____Age:_____

Sex: Male / Female Race:_____Married ( ) Single ( ) Divorced ( )
Spouse Name:_____

Patient Employer: _____Work Phone:_____

Emergency Contact:_____

List Those Persons With Whom We May Share Medical and/or Billing Information With:
_____
_____

Billing Information:
Name:_____Birth Date:_____
Address:_____Phone:_____
Employer:_____Phone:_____

INSURANCE INFORMATION: COPY OF INSURANCE CARDS

I authorize payment to be made to the physician. I authorize any holder of medical information about me to release any information needed to determine the benefits payable for related services to my insurance carrier and/or HCFA agents.

SIGNATURE:_____(if we are filing on insurance)

MEDICAL HISTORY (CIRCLE ALL THAT APPLY)

ANXIETY	ARTHRITIS	ARTIFICIAL JOINTS
ASTHMA	ATRIAL FIBRILLATION	BHP
BONE MARROW TRANSPLANT	BREAST CANCER	COLON CANCER
COPD	CORONARY ARTERY DISEASE	DEPRESSION
DIABETES	END STAGE RENAL DISEASE	GERD
HEARING LOSS	HEPATITIS	HYPERTENSION
HIV/AIDS	HYPERCHOLESTEROLEMIA	HYPERTHYROIDISM
HYPOTHYROIDISM	LEUKEMIA	LUNG CANCER
LYMPHOMA	**PACEMAKER YES OR NO**	PROSTATE CANCER
RADIATION TREATMENT	SEIZURES	STROKE
VALVE REPLACEMENT	NONE OF THE ABOVE	OTHER:

DO YOU WEAR SUNSCREEN? _____IF YES, WHAT SPF?_____
DO YOU TAN IN A TANNING SALON?_____
DO YOU HAVE FAMILY HISTORY OF MELANOMA?_____
IF YES, WHICH RELATIVES?_____
ANY OTHER FAMILY HISTORY?_____

SURGERY HISTORY: (CIRCLE ALL THAT APPLY)

Appendix Removed	**Bladder Removed**	**Mastectomy (Right, Left, Bilateral)**
Lumpectomy (Right, Left, Bilateral)	**Breast Biopsy (Right, Left, Bilateral)**	**Breast Reduction**
Breast Implants	**Colectomy: Colon Cancer Resection**	**Colectomy: Diverticulitis**
Colectomy: IBD	**Gallbladder Removed**	**Coronary Artery Bypass**
PTCA	**Mechanical Valve Replacement**	**Biological Valve Replacement**
Heart Transplant	**Joint Replacement, Knee (Right, Left, Bilateral)**	**Joint Replacement, Hip (Right, Left, Bilateral)**
Joint Replacement within last 2 years	**Kidney Biopsy**	**Kidney Removed (Right, Left)**
Kidney Stone Removal	**Kidney Transplant**	**Ovaries Removed: Cyst or Endometriosis**
Ovaries Removed: Ovarian Cancer	**Prostate Removed: Prostate Cancer**	**Prostate Biopsy**
TURP	**Skin Biopsy**	**Basal Cell Cancer Surgery**
Squamous Cell Carcinoma Surgery	**Melanoma Surgery**	**Spleen Removed**
Testicles Removed (Right, Left, Bilateral)	**Hysterectomy: Fibroids**	**Hysterectomy: Uterine Cancer**

OTHER:_____

MEDICATIONS:_____
_____
_____

ALLERGIES:_____
_____
_____

SKIN DISEASE HISTORY: (CIRCLE ALL THAT APPLY)

ACNE	ACTINIC KERATOSES	BASAL CELL SKIN CANCER
BLISTERING SUNBURS	DRY SKIN	ECZEMA
FLAKING/ITCHY SCALP	HAY FEVER/ALLERGIES	MELANOMA
POISON IVY	PRECANCEROUS MOLES	PSORIASIS
SQUAMOUS CELL SKIN CANCER	NONE OF THE ABOVE	OTHER:

SOCIAL HISTORY:

Cigarette Smoking: Never Former smoker Smokes less than daily Smokes daily

Illicit Drug Use: Drug Use YES OR NO IV Drug Use YES OR NO

Alcohol Use: None Less than 1 drink a day 1-2 drinks a day 3 or more drinks a day

Other_____

PREFERRED PHARMACY:

NAME:

LOCATION: **PHONE:**