Welcome to Carolina Skin Surgery Center

2615 E. 7th St. Charlotte, NC 28204 ~ Phone: 704-295-0000 ~ Fax: 704-295-0005 ~ Marc Carruth, M.D.

Today's Date: _____

Full Name: _____ Date of Birth: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Phone Number (Home): _____ Phone Number (Cell): _____

Phone Number (Work): _____Email Address: _____

Preferred method of contact: ☐ Home ☐Cell ☐ Work ☐ Email

Is it okay to leave a detailed message? ☐ Yes ☐ No

Emergency Contact & Release of Health Information:

Emergency Contact Name: _____ Relationship: _____

Cell Phone Number: _____

Do you give our office permission to discuss medical & billing information with your Emergency Contact? ☐ Yes ☐ No

Do you give our office permission to discuss medical & billing information with other Family Members? ☐ Yes ☐ No

If yes: Name: _____ Name:_____

Contact #: home_____ cell_____ Contact #: home_____ cell_____

Relationship: _____ Relationship:_____

Patient signature: _____

***A signature is required for any information to be released to the above named*

Insurance Information:

Primary Insurance: _____ ID#: _____

Who is the Primary Policy Holder? ☐ Self ☐ Other

If Other, Name and Date of Birth of Primary Policy Holder _____

Secondary Insurance: _____ ID#: _____

Tertiary Insurance: _____ ID#: _____

Please bring your insurance cards to your appointment so we can scan them into our system.

Please read **Authorization to Release Medical Benefits** and sign below once you have read it and agree to its terms

➡ Signature: _____

Name: _____ Date of Birth: _____

Care Team Information:

Referring provider: _____ Primary Care Provider: _____

Phone Number: _____ Phone Number: _____

Additional provider(s) name: _____

Pharmacy Information:

Name: _____ Phone Number: _____

Pharmacy Address: _____

Past Medical History:

Select any of the following medical conditions you currently have or have had in the past:

- ☐ Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation
- 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
- Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Heart Attack
- ☐ NONE

Other

_____

_____

_____

Past Surgical History:

Do you have any of the following? Check if applicable.

☐ Pacemaker ☐ Defibrillator

☐ Artificial Heart Valve Type: _____ Year Performed: _____

☐ Artificial Joint: Which joint(s) & what year(s) performed: _____

Past Surgical History Continued:

Have you had any surgeries on the following organs?

- ☐ Appendix (Removal)
- Bladder (Removal)
- Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Mastectomy (Right, Left, Bilateral)
- ☐ Colon Resection
- Gallbladder (Removal)
- Heart: Coronary Artery Bypass Surgery
- Heart: Heart Transplant
- ☐ Colon: Colostomy
- ☐ Kidney: Kidney Transplant
- ☐ Kidney (Removal)
- Liver (Removal)
- ☐ Liver: Liver Transplant
- ☐ Ovaries (Removal)
- ☐ Spleen (Removal)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ Other:_____

Skin Disease History:

- Pancreas (Removal)
- Prostate Biopsy
- Prostate (Removal)

Have you had any of the following?

- ☐ Actinic Keratoses
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Flaking or Itchy Scalp
- ☐ Melanoma
- ☐ Precancerous Moles
- ☐ Squamous Cell Skin Cancer
- ☐ Other_____
- ☐ None

Do you tan in a tanning salon?

○ Yes ○ No

Do you have a family history of Melanoma?

○ Yes ○ No

If yes, which relative?

- ☐ Mother
- Father
- Sister
- Brother
- Daughter
- ☐ Son
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Other: _____ _____

Do you wear sunscreen?

Yes ○ No

Family History of Skin Cancer:

Please include only first-degree relatives (Ex: Mother, Father, Grandparents):

_____

_____

Medications:

List all current medications (***including the dose and frequency***):

_____
_____
_____
_____

Allergies:

List all allergies and reactions if known:

_____
_____
_____

Social History:

Smoking Status (please choose one):

Current every day smoker
Current someday smoker
Former smoker
Never smoker

Start Smoking:

- Date: _____

Quit Smoking:

- Date: _____

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (please choose one):

No, I don't drink alcohol
Yes, I drink alcohol

If Answered Yes, how many **DAYS** in the past year have you had 5 or more drinks in one day for men, or 4 or more drinks in one day for women?

☐ 0 – 1 **DAYS**
☐ 2 – 3 **DAYS**
☐ 4 or more **DAYS**