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: ____

Cell Phone Number: ____

Do you give our office permission to discuss medical information with 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 visit our website (carolinaskinsurgery.com/insurance) to review the list of insurances that we accept.
- Please read "Authorization to Release Medical Benefits" and sign here once you have read it.

  ➡ Signature: ____
- Please review our Financial Policy and sign here once you have read it.

  ➡ Signature: ____

Pharmacy Information:

Name: ____ Phone Number: ____

Pharmacy Location: ____

Revised: 3/2017

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Name : ______________________________ **Date of Birth:** ______________________

Care Team Information:

Referring provider: ______________________________
Phone Number: ______________________________

Primary Care Provider: ______________________________
Phone Number: ______________________________

Additional provider name: ______________________________
Specialty: ______________________________
Phone Number: ______________________________

Additional Provider Name: ______________________________
Specialty: ______________________________
Phone Number: ______________________________

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 ☐ NONE

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
- ☐ Colon: Colostomy
- ☐ Gallbladder (Removal)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: (Removal)
- ☐ Liver: (Removal)

- ☐ Liver: Liver Transplant
- ☐ Ovaries: (Removal)
- ☐ Pancreas: Removal
- ☐ Prostate Biopsy
- ☐ Prostate: (Removal)
- ☐ Spleen (Removal)
- ☐ Hysterectomy

☐ Other: ____

Past Surgical History (Continued)

☐ Pacemaker ☐ Defibrillator

☐ Artificial Heart Valve
(Type: ______________ Year Performed: __________)

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

Skin Disease History

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
- ☐ NONE
- ☐ Other

____
____

Do you tan in a tanning salon?

○ Yes ○ No

Do you have a family history of Melanoma?

○ Yes ○ No

If yes, which relative?

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

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***):

____
____
____
____
____

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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):

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**

To be completed by CSSC:

Provider Reviewed: ____________________

Date of Review: ________________________