



Alabama Dermatology Associates

Medical, Surgical and Cosmetic Skin Care Specialists

PATIENT INFORMATION

Date: _____

Please Print

Complete Name: _____ Birthdate: _____

First

Middle

Last

Month

Day

Year

Mailing Address: _____ SS#: _____

Street

City

State

Zip

Email: _____ Place of Employment: _____

Telephone #'s (including area code): _____

Home

Cell

Other

Which should we call first? ☐ Home ☐ Cell ☐ Other May we leave a voicemail or text message? ☐ Yes ☐ No

(If Student) Home Address: _____ City: _____ State: _____ Zip: _____

Insurance Name: _____ Contract#: _____ Group #: _____

Insured's Name: _____ Birthdate: _____

Month Day Year

Person Responsible for Bill: _____ Relation to Patient: _____

Mailing Address of Person Responsible: _____

Place of Employment of Person Responsible: _____

Primary Care Physician: _____ Referring Physician: _____

If you prefer, the following information may be entered online through your EMA Patient Portal at alabamaderm.com or alabama.ema.md (contact patientportal@alabamaderm.com for your user name and password)

Gender: ☐ Female ☐ Male Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed or Widower
Ancestry: ☐ African ☐ Asian ☐ European ☐ Other: _____ Are you Hispanic or Latino? ☐ Yes ☐ No
Preferred Language: ☐ English ☐ Spanish ☐ Other: _____
Pharmacy Name, Street and City: _____

Medical History: (Please list all your medical problems or conditions)

Surgeries: _____

Skin Disease(s): _____

Do you wear sunscreen? ☐ Yes ☐ No ☐ SPF? _____

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

Do you have a family history of melanoma?

☐ Yes ☐ No Which relative? _____

Current Medications: (including vitamins, supplements, herbals, over-the-counter, aspirin, and those for skin conditions)

Do you have any MEDICATION ALLERGIES?

☐ YES ☐ NO If yes, please list: _____

Alcohol? ☐ None ☐ Less than 1 drink/day

☐ 1-2 drinks/day ☐ 3 or more drinks/day

Tobacco? ☐ Current every day smoker

☐ Current some day smoker ☐ Former smoker

☐ Never smoker