LLOYD D BRENDEN, MD, FAAD
7525 E BROADWAY ROAD, SUITE 10
MESA, AZ 85208
Phone: (480) 985-9492
Fax: (480) 985-9771
Website: www.lloydbrendenmd.com

PATIENT DEMOGRAPHICS AND REGISTRATION

Name_____Birth Date_____Gender_____
First Middle Last

Local Billing Address: _____
Other Billing Address:_____
Preferred Phone Number: _____ Other Phone:_____
Primary Care Doctor:_____ Phone:_____
Pharmacy_____ Cross-Streets and Town_____

Primary Insurance:_____Copay (Specialist) Amt: $_____
Policy ID/Member ID#_____ Group Number: _____
Policyholder Name: _____Birth Date_____ Relationship to Patient:_____
Policyholder SS#_____Phone_____Employer_____
"Claims to" Address: _____

Second insurance:_____Copay (Specialist) Amt: $_____
Policy ID/Member ID#_____ Group Number: _____
Policyholder Name: _____Birth Date_____ Relationship to Patient:_____
Policyholder SS#_____Phone_____Employer_____
"Claims to" Address: _____

Who can we give your protected information to? _____ No one
Protected Health Information (PHI): Please list name(s) of those to whom you permit us to release your PHI. **If no one is listed, no one other than yourself will be given your information, even if they call at your request**.
Name:_____ Relationship:_____ Phone_____
Name:_____ Relationship:_____ Phone_____
Name:_____ Relationship:_____ Phone_____

Do we have your permission to leave voicemail messages on your phone regarding test results and appointments? Yes_____ No_____
I have received a copy of the Privacy Rules from this provider and authorized the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider.

Signature: _____ **Date:** _____
Circle One: Patient Parent Guardian

Patient Name: _____

Please list any **medications or other substances to which you've had an allergic reaction, and the type of reaction** you had from it:

_____ I have no known drug allergies

_____ I have had allergic reactions to the following medications or substances:

Name of Medication or Substance:	Type of Reaction:
_____	_____
_____	_____
_____	_____

Please provide us with a complete list of your current medications, including dosage, frequency, for what condition, and how long you've been taking it. Please include over-the-counter, herbals, vitamins and other supplements:

Name of Medication:	Dosage:	Frequency:	Route:	For What?	For How Long?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Please let us know if you have had a **history of skin cancer** in the past and list the type, location and approximate year it was treated.

_____ No, I have not had any skin cancers in the past.
_____ Yes, I have had a history of skin cancer, and I have listed each below:

Type: (basal cell, squamous cell, melanoma, other)	Location: (nose, back, etc)	Year:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any **family history of melanoma** skin cancer? _____No _____Yes
If yes, what is the family relationship to you? (Father, sister, etc) _____

Patient Name _____

Have you had **any prior history of skin conditions** such as acne, rosacea, shingles, eczema, psoriasis in the past? If so, please list the condition and when you have had it: (for example: had it as a teenager, comes and goes, diagnosed 4 years ago, having it currently, etc)

_____ _____
Condition When?

_____ _____
Condition When?

_____ _____
Condition When?

Have you had a **history of other medical conditions** such as diabetes, hypertension, breast cancer, etc? If so, please list:

_____ year _____ year
_____ year _____ year
_____ year _____ year

Have you had a history of any of the following infections?
(Please circle if so): Tuberculosis, HIV, Valley Fever, MRSA

Please list any **surgeries** you have had, and the approximate year of the surgery:

_____ year_____ _____ year_____
_____ year_____ _____ year_____
_____ year_____ _____ year_____

Social History:

Please circle one: single married divorced widowed
Number of living children? _____ _____ I live alone. _____I live with (parent, son, daughter, partner, spouse, friend, etc)
Tobacco use? ____ If yes, cigarette/pipe/chew/vape/cigar Quantity/day _____
Started at what age? _____ Quit when? _____
Alcohol use? ____ If yes, number of drinks per week?_____
Spend time in the sun for work or pleasure? _____ Use sun protection? _____ if so, what type (sunscreen, hat, long sleeves)_____
Employment: ___currently employed ___currently unemployed ___retired
Present Occupation: _____Former Occupation: _____

Today's Visit:
What is the reason for today's visit? _____
_____