HENRY E. WILEY, III, M.D.
DIPLOMATE AMERICAN BOARD OF DERMATOLOGY

PATIENT REGISTRATION

NAME: ______________________ DATE OF BIRTH: ____________ AGE: ________

ADDRESS: ______________________ MARITAL STATUS: ____________ SEX: M F

CITY/STATE: ____________ ZIP CODE: ________ HOME TELEPHONE: ______________________

EMAIL ADDRESS: ______________________ WORK TELEPHONE: ______________________

EMPLOYER: ______________________ OCCUPATION: ______________________

SPOUSE OR PARENT: ______________________ REFERRED BY: ______________________

INSURANCE CO: ____________ D.O.B. ________ I.D./GROUP #: ______________________

INSURED NAME: ______________________ PATIENT SOCIAL SECURITY #: ____________

SECONDARY INSURANCE CO. ______________________

MEDICATION ALLERGIES: ______________________

LATEX ALLERGY: YES or NO (please circle)
TAPE ALLERGY: YES or NO (please circle)

CURRENT MEDICATIONS: ______________________

PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT APPLY TO YOU:

1. MELANOMA, SKIN CANCER (Basal Cell Carcinoma, Squamous Cell Carcinoma), or PRECANCERS
2. HISTORY IN YOUR FAMILY OF MELANOMA or OTHER SKIN CANCER
3. ASTHMA, ECZEMA, or HAYFEVER
4. HEART MURMUR, RHEUMATIC FEVER, ARRYTHMIA, HIGH BLOOD PRESSURE, PACEMAKER or HEART ATTACK
5. TRANSPLANT: KIDNEY, LUNG, LIVER, PANCREAS, or HEART
6. DIABETES, THYROID DISEASE, KIDNEY STONES, or LIVER DISEASE
7. INTERNAL MALIGNANCY, if so, please explain ______________________
8. CURRENTLY PREGNANT or BREASTFEEDING
9. ANY OTHER HEALTH PROBLEM, if so, please explain ______________________

IS THERE A FAMILY MEMBER OR CLOSE CONTACT TO WHOM YOUR MEDICAL INFORMATION MAY BE DISCLOSED?
IF SO, PLEASE SPECIFY:
NAME: ______________________ TELEPHONE ____________

EMERGENCY CONTACT: NAME ______________________ TELEPHONE ____________

I CERTIFY THE ABOVE INFORMATION IS COMPLETE AND CORRECT
PATIENT (or GUARDIAN) **SIGNATURE**: ______________________ DATE: ____________