First Coast Mohs
6890 Belfort Oaks Place
Jacksonville, FL 32216
Phone: 904-296-1313
Fax: 866-903-4727

Dermatology Associates of FCM
9905 Old St. Augustine Road
Jacksonville, FL 32257
Phone: 904-880-7715
Fax: 904-880-7721

First Coast Mohs of Ponte Vedra
216 Ponte Vedra Park Drive
Ponte Vedra Beach, FL 32082
Phone: 904-296-1313
Fax: 866-903-4727

PATIENT INFORMATION

Patient Name: _____
Last First Middle Initial

Address: _____

City: _____ State: _____ Zip code: _____

Social Security#: _____ Date of Birth: _____ Sex: ____ Male ____ Female

Home Phone:( )_____ Cell:( )_____ Email: _____

Marital Status: ___ Single ___Married ___Divorced ___Widowed Employed: ____full time ____ part time ____ retired

Name of Employer _____ Phone: _____

Emergency Contact Name: _____ Phone: ( ) _____

Referring Doctor:_____ Phone: ( )_____

INSURANCE INFORMATION

Name of Primary Ins: _____ Name of Secondary Ins: _____

Policy (ID#) _____ Policy (ID#)_____

Group ID # _____ Group ID# _____

RESPONSIBLE (OR INSURED) PARTY INFORMATION

****If all the information below is the same as above please disregard this section****

Name of Employer _____ Phone: _____

Policyholder/Responsible Party Name: _____ DOB:_____

Social Security Number: _____Relationship to patient: _____

DO WE HAVE PERMISSON TO:

LEAVE A MESSAGE ON YOUR ANSWERING MACHINE AT HOME? YES____ NO ____

LEAVE A MESSAGE ON YOUR CELL PHONE? YES____ NO ____

DISCUSS YOUR RESULTS, APPOINTMENTS OR
BILLING MATTERS WITH A FAMILY MEMBER? YES ____NO ____

IF YES, PLEASE GIVE NAME AND NUMBER:

NAME: _____ PHONE:( )_____

Patient Signature: _____ **Date**: _____

Scott D. Warren, MD, PA

First Coast Mohs of Ponte Vedra
216 Ponte Vedra Park Dr.
Ponte Vedra Beach, FL 32082

First Coast Mohs
6890 Belfort Oaks Place
Jacksonville, FL 32216

First Coast Mohs of Mandarin
9905 Old St. Augustine Road
Jacksonville, FL 32257

- **MIPS Quality is the federal program that all providers are required to report in addition to all other information to complete your healthcare visit. Failure to report will lead to penalties imposed by the federal government. Please take a moment and answer the below questions. Thank you.**

NAME:_____ **DATE OF BIRTH:**_____ **AGE:** _____

Primary Care Physician (PCP): _____ **PCP address:**_____

History and Intake Form

Past Medical History: (please circle all that apply and treating Physician in the shaded box)

COPD (Emphysema): Treating Physician _____ **Last visit date**_____/_____

Coronary Artery Disease: Treating Physician _____ **Last visit date**_____/_____

Hypertension: Treating Physician: _____ **Last visit date**_____/_____

Diabetes: Treating Physician: _____ **Last visit date**_____/_____

NONE
Anxiety
Arthritis
Artificial Heart Valve
Artificial joints
Asthma
Atrial fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Chemotherapy
Colon Cancer
Depression
End Stage Renal Disease
GERD (Acid reflux)
Hearing Loss
Hemophilia
Hepatitis **A B C**
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lupus
Lymphoma
Organ Transplant
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement

Other _____

- **110 Have you had an influenza vaccine in the past 12 months (FLU SHOT)** **YES / NO**
- **111 Have you had a Pneumonia vaccine in the past 5 years (Pneumovax)** **YES / NO**

Past Surgical History: (please circle all that apply)

NONE
Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

Other: _____

Skin Disease History: (please circle all that apply)

NONE
Basal Cell Carcinoma
Squamous Cell Carcinoma
Melanoma
Acne
Actinic Keratosis
Asthma
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Poison Ivy
Precancerous Moles/Dysplastic Nevus
Psoriasis

If, you have had a **Melanoma**: Did you have X-ray, CT Scan, Pet Scan or Referred to Oncology for treatment? (Circle those that apply) **137,138,224**

Other: _____

Do you wear Sunscreen? **YES/NO**
If yes, what SPF? _____
Do you tan in a tanning salon? **YES/NO**

- **130 List of all Medications /Dosages/Strength/Route Taken/(By Mouth, Injection, Topical) How often you take them. (Please enter all/provide list current medications or write NONE)**

_____
_____
_____

Allergies: (Please enter all allergies or write NONE)

_____
_____

Social History:

- **- 431 Do you drink alcohol?** **YES/NO**

  IF YES

  Women

  In the last year have you had 4 or more drinks in one sitting? **YES/NO**

  How many times in the last year? _____

  Men

  In the last year have you had 5 or more drinks in one sitting? **YES/NO**

  How many times in the last year? _____

- **- 226/402 Do you smoke or use Tobacco?**
  a. Never Smoked
  b. Quit: former smoker
  c. Smokes less than daily
  d. Smokes daily

Family History: Circle the following conditions that are in your immediate family (Mother, Father, Brother, Sister)

Basal Cell Carcinoma Squamous Cell Carcinoma Melanoma

Please specify: _____

Race:
White
Black/African American
Asian
American Indian/Native Alaskan
Native Hawaiian/Pacific Islander

Language:
English
Spanish
Other: _____

Ethnicity:
Hispanic/Latino
Not Hispanic/ Not Latino
Decline to Specify

Pharmacy:

Name:_____ Phone Number: _____

Address:_____ Zip:_____

Review of Systems: (Please circle one)
Problems with bleeding
Problems with healing
Problems with scarring
Problems with rash
NONE

Alerts: (Please circle one)
Currently Pregnant
Planning on Becoming Pregnant
NOT APPLICABLE

Signature:_____ Date:_____