



James F. Robinson, M.D.

1603 Santa Rosa Road | Suite 203 | Richmond, VA 23229 P 804.440.DERM(3376)

Patient Registration Information

checkbox New Patient checkbox Name Change checkbox Address Change checkbox Insurance Change

Patient Information:

Today's Date: ___/___/___

Name: Last First M.I.

Mailing Address: Number Street Apt. City State Zip

Home Phone: () Work Phone: () Cell Phone: ()

E-Mail Address: May we contact you via e-mail? checkbox Yes checkbox No

Social Security # Date of Birth: ___/___/___ Age: ___

Sex: checkbox Male checkbox Female Marital Status: checkbox Single checkbox Married checkbox Divorced/Separated checkbox Widowed

Insurance Coverage - Primary

Insurance Company Name: Phone ()

Name of Policy Holder (Insured) Insured Date of Birth ___/___/___

Insured Social Security # Sex: checkbox Male checkbox Female

Policy # Group Name or # Policy Type: checkbox HMO checkbox PPO

Employer Name Employee Address

If patient is a child, check relationship: checkbox mother checkbox father checkbox other

Insurance Coverage - Secondary

Insurance Company Name: Phone ()

Name of Policy Holder (Insured) Insured Date of Birth ___/___/___

Insured Social Security # Sex: checkbox Male checkbox Female

Policy # Group Name or # Policy Type: checkbox HMO checkbox PPO

Employer Name Employee Address

If patient is a child, check relationship: checkbox mother checkbox father checkbox other

For Minors: Responsible Party

Name: Last First M.I.

Mailing Address(if different from above):

Social Security Number: Relationship:



James F. Robinson, M.D.

1603 Santa Rosa Road | Suite 203 | Richmond, VA 23229 P 804.440.DERM(3376)

Patient Medical History

Name: Last First M.I. Date: / /

Reason for today's visit:

Are you allergic to any medications? YES NO

If yes, please list:

Are you allergic to latex? YES NO

List all medications you are currently taking including all prescriptions, vitamins and herbal supplements:

Do you have now, or have you ever had any of the following diseases or conditions:

Table with columns for YES and NO, and rows for Lungs, Vascular, Other Systemic, and Other conditions.

Please note any reactions:

List any other disease or conditions we should know about:

List surgical procedures you have had in the last 6 months: _____

Do you have a history of any specific skin diseases? _____

Please answer the following questions

When you are exposed to sun do you: Tan Only Burn and Tan Burn
Have you ever had skin cancer: YES NO
Has anyone in your family had skin cancer? YES NO If YES, who / relation? _____
Are you in the sun frequently? YES NO

Are you currently using:
Retin A YES NO
Renova YES NO
Glycolic YES NO
Retinol YES NO
Tazorac YES NO

Are you currently or have you taken Accutane in the last 12 months? YES NO

Are you currently using any other creams/lotions? YES NO If yes, please list: _____

Are you currently or have you in the past:
Waxed YES NO
Tweezed YES NO
Used a depilatory YES NO
Used a tanning booth YES NO

Other comments: _____

Please sign below to indicate all of the information on this form is accurate and complete.

Completed by: Patient Parent / Guardian (please initial) _____

Patient Signature: _____ Date: _____