Strimling Dermatology, Laser & Vein Institute - Patient Info Update Form **Date_____**

Patient Name _____ Birthdate_____

	Please answer the following questions by checking Yes or No.	Yes	No
1.	Any changes to you mailing address, phone number(s) or contact information since your last appointment? **If Yes, please indicate new mailing address, phone number(s) or other contact information below:**		
	Mailing Address:		
	Mobile #: Home #: Work #:		
	New Email:		
	New Emergency contact person, relationship to patient and contact phone #:		
		Yes	**No**
2.	**Any changes in your employment or student status since your last appointment?** If Yes, please indicate: ☐ Employed and Employer_____ or ☐ Retired or ☐ Student		
		Yes	**No**
3.	**Any changes to your health insurance since your last appointment?** If Yes, please provide your **most recent insurance card or information** to our check-in staff. Please check with our staff if you are unsure about whether or not we have your up-to-date insurance information.		
		Yes	**No**
4.	**Any changes to your health / medical history since your last appointment, including:**		
	• Any new or discontinued medications, For any new medications, please indicate the medication name, dose, frequency (i.e. how often you take the medication) and route of administration (e.g. orally) here: _____ _____		
	• Any new medication allergies,_____		
	• Any new medical problems or change in status of existing medical problems,_____		
	• Any new or recent diagnostic studies, including lab or radiologic tests,_____		
	• Any recent surgeries,_____		
	• Any changes in your family or social history that maybe significant,_____		
	• And / or any new or changing symptoms,_____		
	If female, are you pregnant or nursing?		
	If you answered Yes to Question #4 above, please indicate any changes above or here:_____ _____		
	Annual CMS Quality Payment Program (QPP) Merit-based Incentive Payment System (MIPS) Measures: Please answer annually. If you have already answered these questions within this calendar year, please omit.	**Yes**	**No**
1.	**Do you use tobacco?** If Yes, we strongly urge you to quit as tobacco use increases your risk of heart disease, stroke and cancer.		
2.	**Are you an "Unhealthy Alcohol User"?*** If you answered Yes, we advise you to seek help to stop. *Unhealthy alcohol use may be defined in various ways, including any use of alcohol that increases the risk of health consequences or has already led to health consequences; men who drink more than 4 drinks per day or more than 14 drinks per week and women who drink more than 3 drinks per day or more than 7 drinks per week; or any alcohol use that causes an individual to have difficulty in his/her life as a result of drinking alcohol. Other definitions include drinking under the age of 21 years of age, drinking while pregnant, alcohol dependence, binge drinking among others.		
3.	**Have you been immunized for influenza this year?** The CDC recommends everyone 6 months of age and older get a flu vaccine every season (unless you are allergic to the vaccine or have another contraindication). Talk to your primary care doctor about this vaccine.		
4.	**If you are over the age of 65, have you received the pneumococcal vaccine?** The CDC recommends pneumococcal vaccination for all children younger than 2 years old and adults 65 years and older and some other situations, (unless you are allergic to the vaccine or have another contraindication). Talk to your primary care doctor about these vaccinations.		
5.	Do you have a medical advanced directive (e.g. living will or durable power of attorney or other medical directive) or surrogate medical decision maker? If yes, please provide us with a copy or the name of your surrogate medical decision maker here if you have not already done so:_____ If no, we hereby advise you to consider this, including discussing this with your family, attorney and/or primary care provider.		

☐ discussed with patient / reviewed by provider / physician ☐ reviewed by staff / any changes entered into EMR