SASKATOON
DERMATOLOGY
CENTRE
MEDICAL, SURGICAL, AESTHETIC SPECIALISTS

3- 303 Stonebridge Blvd
Saskatoon, SK S7T 0G3
Ph. (306) 373-0040

Patient Intake Assessment Form

Name: _____ DOB: _____ Age: _____
(as it appears on your health card)
Address: _____ Health Card Number: _____
City/Town/Village: _____ Province: _____ Postal Code: _____
Cell Phone #: _____ Home phone #: _____
Email Address: _____
Family Doctor: _____

✦**Preferred Pharmacy for Prescriptions** _____

Reason for referral to dermatology: _____

*__Please note: We request the appointment focuses ONLY on the referred condition. If there are other issues, we may be able to address these at additional visits or if they are cosmetic in nature, they can be booked in for a cosmetic consultation.__

How long have you had this problem? _____

Have you seen a Dermatologist for this condition, and when? _____

Which medications or treatments have you tried for this problem?

Please list all prescription/non-prescription medications you are currently taking:

1.		2.	
3.		4.	
5.		6.	
7.		8.	

Do you have any **medication allergies**? _____
Allery to anesthetic/freezing? ❑ Yes ❑ No
Do you have a private insurance plan for your medications? (if yes, list provider)
_____ NIHB ❑ Yes ❑ No
Current/ Previous Occupation: _____

Skin History:

Have you had any of the following skin conditions?
❑ Actinic Keratoses ❑ Basal Cell Skin Cancer ❑ Squamous Cell Skin Cancer
❑ Melanoma ❑ Blistering Sunburns ❑ Atypical Moles
Specify location and date: _____

Family medical history of melanoma ❑ Yes ❑ No
Do you wear sunscreen? ❑ Yes (what SPF? _____) ❑ No ❑ Sometimes
Have you ever used a tanning salon? ❑ Never ❑ In the past: (How many times? _____
❑ Current tanner: (How often do you go tanning per year? _____)

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Medical History:

Do you drink alcohol? ❑ None ❑ <1 drink per week ❑ 1-7 drinks per week ❑ 7+ drinks/wk.
Do you smoke? ❑ Never smoked ❑ Former smoker ❑ Current smoker: (# packs smoked per day ____)

Please indicate any of your current or previous medical conditions:

❑ Heart Disease, please specify _____
❑ Pacemaker ❑ Liver Disease: _____ ❑ Kidney Disease: _____
❑ Lung Disease: please specify _____
❑ Transplantation: please specify _____
❑ Autoimmune Disease: please specify _____
❑ Neurologic Disease please specify _____
❑ Cancer (Type, Year): _____
❑ Anxiety ❑ Depression ❑ HIV/AIDS ❑ Hepatitis B/C
❑ Other conditions not listed:
_____
Are you: ❑ Pregnant (How many weeks_____) ❑ Trying to become pregnant ❑ Breast-feeding

Clinic Policies

We strive to provide the highest quality dermatologic care during your visit. While your Saskatchewan Medicare pays for a wide range of required services provided by physicians, some physician services are not insured by Saskatchewan's Ministry of Health. **You are responsible for payment of these uninsured services.**

I, _____, (patient name or guardian if patient is under 18), acknowledge the following:

1. I agree to pay the missed appointment fee of **$50.00*** for a new appointment and **$30.00*** for a followup appointment if I do not notify the office at least 24 hours before cancelling/rescheduling/failing to attend my scheduled appointment. Please note patients who fail to attend may be discharged from our practice, back into the care of their referring doctor. *Fees for missed procedures may be higher.

2. I agree that the costs associated with uninsured medical services including the completion of **insurance forms ($50.00), sick notes ($25.00), letters of attendance ($10.00),** as outlined by and in accordance with the Saskatchewan Medical Association. For a full list of uninsured services, see the front desk.

✦ **Signature:** _____ **Date:** _____