Dermatology & Mohs Surgery Institute
Patient Registration Form

Date

Patient Information: Please print clearly

☐ **Male**
☐ **Female**

Last:_____ **First**:_____ **MI**:_____

Preferred Name:_____ **Prefix**:_____ **Suffix**:_____ **DOB**:__ __ / __ __ / __ __ __ __

SS #: __ __ __ - __ __ - __ __ __ __ **Marital Status**: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Other: _____

Language: ☐ English ☐ Other: _____ **Ethnicity**: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Billing or Mailing Address: _____

City: _____ **State**: _____ **Zip**: _____

Primary Phone: (___ ___ ___) ___ ___ ___-___ ___ ___ ___ ☐ Home ☐ Cell

Secondary Phone: (___ ___ ___) ___ ___ ___-___ ___ ___ ___ ☐ Home ☐ Cell

Email: ___

Emergency Contact: _____ **Relationship**: _____ **Phone**: (__ __ __) __ __ __ - __ __ __ __

Employment status: ☐ Employed ☐ Not Employed ☐ Retired ☐ Student ☐ Disabled

Employer: _____ **Occupation**: _____

How did you hear about us? _____

Guarantor Information: Complete only if the patient is a minor or has an appointed Power of Attorney.

☐ Male
☐ Female

Legal Name: _____ DOB: __ __ / __ __ / __ __ __ __

SS #: __ __ __ - __ __ - __ __ __ __ Relationship: _____ Phone: (__ __ __) __ __ __ - __ __ __ __

Billing Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Sharing of Medical Information

I give the physician and office staff of DMSI permission to discuss my medical condition with the following individuals, if none please select none:

(You must add your spouse or your emergency contact if you wish for us to be able to talk with them.)
(Ask our Receptionist for additional space for Sharing of Medical Information.)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

☐ None

Communication

I would like Voicemails to be left on the phone number I provided: ☐ Yes ☐ No

If Yes I specifically authorize Voicemails to be left for: ☐ Appointments ☐ Results ☐ Medication Issues

Primary Insurance

Name of Insurance: _____

Name of Policy Owner: _____ Policy Owner's DOB: __ __/__ __/__ __ __ __

Policy Owner's Employer: _____ Relationship to Patient: : ☐ Self ☐ Spouse ☐ Parent

Secondary Insurance

Name of Insurance: _____

Name of Policy Owner: _____ Policy Owner's DOB: __ __/__ __/__ __ __ __

Policy Owner's Employer: _____ Relationship to Patient: : ☐ Self ☐ Spouse ☐ Parent

Dermatology & Mohs Surgery Institute
Medical History

Patient Name: _____ **DOB:** __ __ / __ __ / __ __ __ __

Medical History: Please check all that apply

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular heartbeat)
- ☐ Benign Prostatic Hypertrophy (BPH)
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ Gastro Esophageal Reflux Disease (GERD)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ High Cholesterol (Hyper Cholesterolemia)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other: _____
- ☐ **None**

Surgical History: Please check all that apply

- ☐ Appendix Removed (Appendectomy)
- ☐ Bladder Removed (Cystectomy)
- ☐ Breast Biopsy (Right, Left, Bilateral)
- ☐ Breast Lumpectomy (Right, Left, Both)
- ☐ Breast Mastectomy (Right, Left, Both)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: (Colon Cancer Resection)
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD – Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Coronary Artery Bypass
- ☐ Joint Replacement, Knee (Right, Left, Both)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Gallbladder Removed (Cholecystectomy)
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ Joint Replacement, Hip (Right, Left, Both)
- ☐ Liver: Liver Removal (Hepatectomy)
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries: Ovary Removal (Oophorectomy)
- ☐ Ovaries: Endometriosis
- ☐ Ovaries: Ovarian Cancer
- ☐ Ovaries: Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreas Removal (Pancreatectomy)
- ☐ Prostate: Prostate Removal (Prostatectomy)
- ☐ Prostate: Prostate Biopsy
- ☐ Prostate: Prostate Cancer
- ☐ Prostate: TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: BCC
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: SCC
- ☐ Spleen: Spleen Removal (Splenectomy)
- ☐ Testicles: Testicle Removal (Orchiectomy)
- ☐ Uterus: Uterus Removal (Hysterectomy)
- ☐ Uterus: Fibroids
- ☐ Uterus: Uterine Cancer
- ☐ Uterus: Cervical Cancer
- ☐ Other: _____
- ☐ **None**

Skin Disease History: Please check all that apply

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Basal Cell Carcinoma
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/ Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma
- ☐ Other: _____
- ☐ **None**

Both sides of this page must be completed. Bring this form with you into the exam room.
Do not return this form to the front desk.

Patient Name: _____ DOB: __ __ / __ __ / __ __ __ __

Medications: Please list Medication Name

_____

_____

_____

_____ ☐ **None**

Allergies: Please list all allergies

_____

_____

_____ ☐ **No Known Allergies**

Social History: Please check one

Tobacco Use: ☐ Never ☐ Quit ☐ Less than daily ☐ Daily

Alcohol Use: : ☐ Never ☐ Yes: How much and how often_____

Family History

Do you have a family history of Melanoma? ☐ Yes ☐ No

If yes, which relative(s)? _____

Any other family history: _____

Review of Systems

Are you Pregnant? ☐ Yes, Due Date_____ ☐ No ☐ Not Applicable

Are you planning to become pregnant? ☐ Yes ☐ No ☐ Not Applicable

Do you have problems with: ☐ Bleeding ☐ Healing ☐ Scarring

Artificial Heart Valve within the past 2 years? ☐ Yes, When_____ ☐ No

Artificial Joints within the past 2 years? ☐ Yes, When_____ ☐ No

Pacemaker? ☐ Yes ☐ No

Blood Thinners or Aspirin? ☐ Yes ☐ No

Referring Physician: Please give as much information as possible

_____ First Name

_____ Last Name

☐ Doctor ☐ Nurse Practitioner
☐ Physician Assistant ☐ Other: _____

_____ Phone Number

_____ Fax Number

_____ Location

Primary Care Physician: Please give as much information as possible

_____ First Name

_____ Last Name

☐ Doctor ☐ Nurse Practitioner
☐ Physician Assistant ☐ Other: _____

_____ Phone Number

_____ Fax Number

_____ Location

Pharmacy: Please give as much information as possible

_____ Name

_____ Location

_____ Phone Number

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