For office use only: ❑EMA ❑Centricity ❑Insurance

Patient Registration Form: PATIENT INFORMATION		
Name:	Date of Birth:	Sex:
Street Address:	City/State:	Zip Code:

Race:	Ethnic Group:	Preferred Language:	**Marital Status:** **Single** **Married** **Divorced** **Widowed**

Employer/Place of Employment: **Employer Phone number:**

Social Security Number:	Spouse Name (if applicable):	Caretaker Name (if applicable):

Pharmacy: *our office sends prescriptions electronically – please list as much information as possible*

Name: ________________________________ Location: _______________________________ Phone: __________________

Have you ever been seen by one of our physicians? ❑ Yes ❑ No (if yes, physician name)

Primary Care Provider: Full Name: _______________________ Location: _______________________________________

Phone: _________________ Fax: _____________________ Did your Primary Care Provider refer you? ❑ Yes ❑ No

Were you referred by another physician? ❑ Yes ❑ No **IF yes:** Name of referring Provider ____________________________

How did you hear about our office (check all that apply)?

❑ Internet ❑ Radio ❑ Yellow Pages ❑ TV ❑ Newspaper ❑ Friend ❑ Relative ❑ Doctor ❑ Other ________________

Medical Information Release (Privacy Policies are located at the reception desk)

Cell Phone: ( )	Home Phone: ( )	Work Phone: ( )	**Email address:** ____________

Please indicate if we may leave a detailed message regarding test results, appointments, and/or billing on any of the following:

❑ Cell Phone ❑ Home Phone ❑ Work Phone ❑ Another party (name/relationship) ____________________________________

❑ **Do NOT leave a detailed message**

Please indicate if we may leave a message for you to return our call:

❑ Cell Phone ❑ Home Phone ❑ Work Phone ❑ Another party (name/relationship) ____________________________________

❑ **Do NOT leave a message to return your call**

Check your preferred method of contact:

❑ Cell Phone
❑ Home Phone
❑ Work Phone
❑ Email

Please list your emergency contact(s) below (name/phone number/relationship):

1. ____

2. ____

Signature of Responsible Party/Date ____

Twin Oaks Dermatology & Eye Surgery Financial Policy

Thank you for choosing Twin Oaks Dermatology and Eye Surgery. The following is our financial policy. Please review the policy, initial where indicated, then sign and date at the bottom.

Paperwork: We request you routinely update your paperwork to ensure we have all the correct information on hand for billing purposes and to ensure excellent clinical care. This paperwork allows us to bill insurances in a timely manner, and prevents balances being unnecessarily transferred to you, the patient. We understand the frustration of completing paperwork and are constantly evaluating different methods to reduce the burden on you.

Paperwork Initial _________

Missed Appointments/Cancellations: We request 24 hour advanced notification of cancellations and reschedules. We try to notify all patients of upcoming appointments using our computerized calling system. Unfortunately, we do experience errors with the system from time to time. We do not charge for missed appointments or cancellations. Frequently missed appointments and/or cancellations can result in dismissal from our practice.

Missed Appointment/Cancellation Policy Initial _________

Insurance: Our practice is contracted with most commercial insurances and Medicare. We only accept some forms of Medicaid. As a contracted provider, we agree to accept adjusted fees from your insurance company and bill in accordance with CPT and ICD 10 guidelines. We collect co-pays at the time of your visit. Deductibles and other outstanding balances will be billed to you, after your claim has been processed by your insurance company. We are unable to determine prior to your visit what charges will be applied to your deductible. The patient is responsible for providing the most up to date insurance information at the time of service. The patient is responsible for payment of services rendered in the event that incorrect insurance information was provided at the time of service. Available forms of payment include: cash, check, American Express, Discover, MasterCard, and Visa.

Does your insurance require a referral? YES___________ NO ____________

If YOU ARE NOT the subscriber on the insurance we NEED the following information to process your claim:

Subscriber Full Name: ____ Relationship to Patient: ____________________

Subscriber DOB: _______________ Subscriber Address (if different from patient): _______________________________________

Insurance Initial ____________

Cosmetic Procedures: **Payment is expected in full at the time of your procedure.**

Cosmetic Initial _________

Lab Fee: Twin Oaks Dermatology and Eye Surgery uses an outside laboratory for pathology services. The lab will bill you directly for these services.

Lab Fee Initial _________

Patient is Responsible for Total Charge: Patients will be billed in full for any unpaid copayments or deductibles. Patient balances will be set by the adjusted rates as determined by our contract with your insurance company. In accordance with our contracts and Medicare guidelines, we cannot make adjustments to these fees or the codes charged. If your insurance requires a referral and the necessary referral was not obtained prior to services rendered, the patient (or party responsible for billing as listed below) is responsible for total payment of services rendered.

Patient Responsibility Total Charge Initial _________

Your statement will come from Dermatologists of Central States, which is our practice management company.

My Signature below indicates that I have read and agree to the above written financial policy of Twin Oaks Dermatology and Eye Surgery.

Signature of Responsible Party/Date ____

Patient Name: ____ Date of Birth: ____________________

Do you have (or have you had) any of the following medical problems (Please check all that apply)

- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation
- ❑ Bone Marrow Transplant
- ❑ BPH Benign Prostatic Hyperplasia
- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ COPD
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes
- ❑ End Stage Renal Disease
- ❑ GERD
- ❑ Hearing Loss
- ❑ Hepatitis
- ❑ Hypertension
- ❑ HIV/AIDS
- ❑ Hypercholesterolemia
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Leukemia
- ❑ Lung Cancer
- ❑ Lymphoma
- ❑ Prostate Cancer
- ❑ Radiation Treatment
- ❑ Seizures
- ❑ Stroke
- ❑ Other ______________________________
- ❑ None

Have you had any surgeries on the following organs listed in columns 1 and 2 below (Please check all that apply)

- ❑ Appendix: Appendectomy
- ❑ Bladder: Cystectomy
- ❑ Breast: Breast Biopsy
- ❑ Breast: Lumpectomy (left breast)
- ❑ Breast: Lumpectomy (right breast)
- ❑ Breast: Mastectomy (left breast)
- ❑ Breast: Mastectomy (right breast)
- ❑ Colon: Colectomy
  Why: ______________________________
- ❑ Colon: Colostomy
- ❑ Gallbladder: Cholecystectomy
- ❑ Heart: Biological Valve Replacement
- ❑ Heart: Coronary Artery Bypass
- ❑ Heart: Heart Transplant
- ❑ Heart: Mechanical Valve Replacement
- ❑ Heart: PTCA Angioplasty: Stent Placement
- ❑ Joint Replacement: Hip (left)
- ❑ Joint Replacement: Hip (right)
- ❑ Joint Replacement: Knee (left)
- ❑ Joint Replacement: Knee (right)
- ❑ Kidney: Kidney Biopsy
- ❑ Kidney: Kidney Stone Removal
- ❑ Kidney: Kidney Transplant
- ❑ Kidney: Nephrectomy
- ❑ Liver: Hepatectomy
- ❑ Liver: Liver Transplant
- ❑ Liver: Shunt
- ❑ Ovaries: Oophorectomy
  Why: ______________________________
- ❑ Ovaries: Tubal Ligation
- ❑ Pancreas: Pancreatectomy
- ❑ Prostate: Prostate Biopsy
- ❑ Prostate: Prostatectomy
- ❑ Rectum: APR Abdominal Perineal Resection
- ❑ Rectum: Low Anterior Resection
- ❑ Skin: Basal Cell Carcinoma
- ❑ Skin: Melanoma
- ❑ Skin: Skin Biopsy
- ❑ Skin: Squamous Cell Carcinoma
- ❑ Spleen: Splenectomy
- ❑ Testicles: Orchiectomy
- ❑ Uterus: Hysterectomy
  Why: ______________________________
- ❑ None
- ❑ Other ______________________________

Have you had any of the following conditions?

(Please check all that apply)

- ❑ Acne
- ❑ Actinic Keratosis (pre-skin cancer)
- ❑ Basal Cell Skin Cancer
- ❑ Blistering Sunburns
- ❑ Dry Skin
- ❑ Eczema
- ❑ Flaking or Itchy Scalp
- ❑ Hay Fever/Allergies
- ❑ Melanoma
- ❑ Poison Ivy
- ❑ Precancerous Moles
- ❑ Psoriasis
- ❑ Squamous Cell Skin Cancer
- ❑ Other ______________________________
- ❑ None

Have you ever tested positive for TB? ❑ Yes ❑ No

Do you have a family history of melanoma? ❑ Yes ❑ No

If yes, which relative(s)? ____________ ____________

Do you wear sunscreen? ❑ Yes ❑ No

If yes, what SPF? ______

Do you use a tanning salon? ❑ Yes ❑ No

Are you currently pregnant? ❑ Yes ❑ No

Previous history of pregnancies/births (list years)

____

Social History

Tobacco Use:

- ❑ Current every day smoker/tobacco user
  (start date) __________
- ❑ Former every day smoker/tobacco user
  (quit date) __________
- ❑ Never

Vaccinations:

Have you received your flu vaccination for the current year?
❑ Yes ❑ No

Have you received your pneumonia vaccination?
❑ Yes ❑ No

Have you ever tested positive for TB?
❑ Yes ❑ No

Alcohol Use

- ❑ No Alcohol Use
- ❑ Less Than 1 drink/day
- ❑ 1-2 drinks/day
- ❑ 3 or more drinks/day

Male patients under 65:

How many times in the past year have you had 5 or more drinks in 1 day? ______________

Patients over 65 and all female patients:

How many times in the past year have you had 4 or more drinks in 1 day? ______________

Signature of Responsible Party/Date ____

Review of Symptoms and Medications

Patient Name: ____ Date of Birth: _____________

REVIEW OF SYSTEMS History or current problem with any of the following? (Please check all that apply)

- Problems with bleeding ❑ Yes ❑ No
- Problems with healing ❑ Yes ❑ No
- Problems with scarring (hypertrophic or keloid) ❑ Yes ❑ No
- Abdominal Pain ❑ Yes ❑ No
- Anxiety ❑ Yes ❑ No
- Bloody Stool ❑ Yes ❑ No
- Bloody Urine ❑ Yes ❑ No
- Blurry Vision ❑ Yes ❑ No
- Chest Pain ❑ Yes ❑ No
- Cough ❑ Yes ❑ No
- Depression ❑ Yes ❑ No
- Dizziness ❑ Yes ❑ No
- Fever or Chills ❑ Yes ❑ No
- Grey Discoloration of Skin ❑ Yes ❑ No
- Hay Fever ❑ Yes ❑ No
- Headaches ❑ Yes ❑ No
- Immunosuppression ❑ Yes ❑ No
- Joint Aches ❑ Yes ❑ No
- Menstrual Changes ❑ Yes ❑ No
- Muscle Weakness ❑ Yes ❑ No
- Neck Stiffness ❑ Yes ❑ No
- Night Sweats ❑ Yes ❑ No

- Rash/Hives ❑ Yes ❑ No
- Seizures ❑ Yes ❑ No
- Shortness of Breath ❑ Yes ❑ No
- Sleeplessness ❑ Yes ❑ No
- Sore Throat ❑ Yes ❑ No
- Thyroid Problems ❑ Yes ❑ No
- Unintentional Weight loss ❑ Yes ❑ No
- Vaginal Candidiasis ❑ Yes ❑ No
- Wheezing ❑ Yes ❑ No
- Red Eye ❑ Yes ❑ No
- Tearing ❑ Yes ❑ No
- Eye Pain ❑ Yes ❑ No
- Uncontrolled Blood Pressure ❑ Yes ❑ No
- Elevated Blood Sugar ❑ Yes ❑ No

- Allergy to Adhesive ❑ Yes ❑ No
- Allergy to Lidocaine ❑ Yes ❑ No
- Allergy to topical antibiotic ointments ❑ Yes ❑ No
- Artificial Heart Valves ❑ Yes ❑ No
- Artificial Joints in the last 2 yrs ❑ Yes ❑ No
- Blood Thinners ❑ Yes ❑ No
- Defibrillator ❑ Yes ❑ No

- MRSA ❑ Yes ❑ No
- Pacemaker ❑ Yes ❑ No
- Currently pregnant or planning a pregnancy ❑ Yes ❑ No
- Premedication prior to procedures ❑ Yes ❑ No
- Rapid heartbeat with epinephrine ❑ Yes ❑ No
- Ebola Risk: Fever >+100.4 ❑ Yes ❑ No
- West Africa: travel or contact ❑ Yes ❑ No
- Ebola Risk: contact w/ebola patient without proper protective equipment within the last 21 days ❑ Yes ❑ No
- Ebola Risk: headaches, weakness, muscle pain vomiting, diarrhea, abdominal pain, and/or hemorrhage ❑ Yes ❑ No

- Prostate Medications ❑ Yes ❑ No
- Transplant ❑ Yes ❑ No
- HIV ❑ Yes ❑ No

Are you currently taking any of the following blood thinners?

❑ **NONE** ❑ **Aspirin** ❑ **Cilostazol (Pletal)** ❑ **Coumadin (Warfarin)** ❑ **Dipyridamole (Aggrenox)** ❑ **Effient** ❑ **Eliquis**

❑ **Pentoxifylline (Trental)** ❑ **Plavix (Clopidogrel)** ❑ **Pradaxa** ❑ **Ticagrelor (Brilinta)** ❑ **Ticlodipin (Ticlid)** ❑ **Xarelto**

Medications – complete list below or attach separate list – must include all prescriptions, over-the counters and vitamins/supplements

Medication Name	Dosage	Frequency	Route

Latex Allergy? ❑ Yes ❑ No

Any Drug Allergies? ❑ Yes ❑ No (If yes, list any drugs you are allergic to)

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Signature of Responsible Party/Date ____