



For office use only: □EMA

□Centricity

□Insurance

	Patie	ent Registr	ation Form: PATIENT	INFORMA	TION		
Name:			Date of Birth:			Se	ex:
Street Address:			·	City/State	e:		Zip Code:
Race:	Ethnic Group:		Preferred Language:		Marital St	tatus	3:
				Single	Married Divo	orce	d Widowed
Employer/Place of Employer/Place	oloyment:			Em	ployer Phone r	num	ber:
Social Security Number:		Spouse N	lame (if applicable):		Caretaker Nar	me (if applicable):
Pharmacy: *our office ser	nds prescriptions ele	ctronically -	please list as much info	ormation as	possible*		
Name:		Location:			Phone:		
Have you ever been seen	by one of our physic	ians?	Yes □ No (if yes, p	physician na	me)		
Primary Care Provider:	Full Name:		Location:				
Phone:	Fax:		Did your Primary Care	e Provider re	efer you?	Yes	□ No
Were you referred by ano	ther physician? □ Y	es □ No I	F yes: Name of referring F	Provider			
How did you hear about o	our office (check all th	nat apply)?					
☐ Internet ☐ Radio ☐ Yel	low Pages □ TV □ N	ewspaper 🗆	Friend ☐ Relative ☐ Doo	ctor 🛚 Othe	er		
ľ	Medical Information	n Release (Privacy Policies are lo	ocated at t	the reception d	esk)	
Cell Phone:	Home Phone:		Work Phone:	Email	address:		
()	()		()				
Please indicate if we ma	y leave a detailed me	essage rega	rding test results, appoir	ntments, an	d/or billing on ar	ny of	the following:
☐ Cell Phone ☐ Home F	Phone 🔲 Work Phon	e 🛭 Anothe	er party (name/relationship))			
				□ Do NOT I	eave a detailed r	ness	age
Please indicate if we may	leave a message for	you to retur	n our call:				
☐ Cell Phone ☐ Home I	Phone 🔲 Work Phor	ne 🗖 Anothe	er party (name/relationship	o)			
				□ Do NOT	leave a message	e to ı	eturn your call
Check your preferred rof contact: Cell Phone Home Phone Work Phone Email			ergency contact(s) be				

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: Relationship to Patient: Subscriber Full Name: 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: Do you have (or have you had) any of the following medical problems (Please check all that apply)							
Anteriory	Patient Name:			Date of Birth:			
Anthrilins	Do you have (or	have you had) a	ny of the following medical p	roblems (Please check	all that apply)		
Author Diabetes Proprint None None	☐ Anxiety	Coronary Arte	ry Disease	☐ Hypercholesterolemia	□ Stroke		
Bridstand End Stage Renal Disease Lueksenia None Service Cancer Lung Cancer Lung Cancer Lung Cancer Service Cancer Hepatitis Proteits Cancer Reduction Treatment Proteits Cancer Hepatitis Proteits Cancer Reduction Treatment Proteits Cancer Hepatitis Proteits Cancer Hepatitis Proteits Cancer Head of the structure Reduction Treatment Proteits Cancer Head of the structure Reduction Treatment Proteits Cancer Head of the structure Reduction Treatment Proteits Cancer Reduction Treatment Proteits Cancer Reduction Treatment Proteits Cancer Reduction Reduction Treatment Reduction Proteits Cancer Proteits Cancer Reduction Reduction Proteits Cancer Prote	☐ Arthritis	Depression		Hyperthyroidism	□ Other		
British Familiation	☐ Asthma	□ Diabetes		□ Hypothyroidism			
Bristact Cancor Hepatitic Hepatitic Proteinte Cancor Proteinte Proteinte Cancor Proteinte Cancor Proteinte Prote	☐ Atrial Fibrillation	☐ End Stage Re	nal Disease	□ Leukemia	☐ None		
Breast Cancer	☐ Bone Marrow Transplant	☐ GERD		Lung Cancer			
GOPD Have you had any surgeries on the following organs listed in columns: 1 and 2 below (Please check all that apply)	☐ BPH Benign Prostatic Hyperplasia	Hearing Loss		□ Lymphoma			
Appendix Appendix Appendix Appendix Profitation	☐ Breast Cancer	☐ Hepatitis		□ Prostate Cancer			
Have you had any surgeries on the following organs listed in columns 1 and 2 below (Please check all that apply) Appendix: Appendectomy	□ Colon Cancer	Hypertension		☐ Radiation Treatment			
□ Appendix. Appendectomy □ Bidder: Cystectomy □ Bidder: Shunt □ Breast: Example conny (fight breast) □ Breast: Example conny (fight breast) □ Breast: Example conny (fight breast) □ Breast: Mastectomy (fight breast) □ Colon: Colostomy □ Prostate: Prostate Biopsy □ Prostate: Prosta	□ COPD	☐ HIV/AIDS		☐ Seizures			
Billader Cystectomy	Have you had any surgeries on the following organs listed in columns 1 and 2 below (Please check all that apply)						
Breast Biopsy Liver; Shunt Acne Acne Acne Acne Actinic Keratosis (pre-skin cancer) Breast Lumpectomy (right breast) Ovaries: Ophorectomy Actinic Keratosis (pre-skin cancer)	☐ Appendix: Appendectomy	☐ Liver: Hepated	ctomy	Have you ha	ad any of the following	ng conditions?	
Ovaries: Cophorectomy (left breast)	☐ Bladder: Cystectomy	☐ Liver: Liver Tr	ansplant	(Plea			
Breast: Lumpectomy (right breast)	☐ Breast: Breast Biopsy	☐ Liver: Shunt		☐ Acne			
□ Breast: Mastectomy (left breast) □ Breast: Mastectomy (left breast) □ Colon: Colotectomy Whyr □ Colon: Colotectomy Whyr □ Colon: Colotectomy □ Prostate: Prostate Biopsy □ Prostate: Prostate Biopsy □ Recturn: Low Anterior Resection □ Return: Low Anterior Resection □ Heart: Biological Valve Replacement □ Heart: Coronary Artery Bypass □ Heart: Mechanical Valve Replacement □ Heart: PTCA Angioplasty: Stent Placement □ Joint Replacement: Hip (left) □ Joint Replacement: Hip (left) □ Joint Replacement: Kine (left) □ Joint Repla	☐ Breast: Lumpectomy (left breast)	☐ Ovaries: Ooph	norectomy	☐ Actinic Keratosis (pre-skin cancer)			
Discust: Mastectomy (right breast)	☐ Breast: Lumpectomy (right breast)	Why:		☐ Basal Cell Skin Cance	r		
□ Colon: Colectomy Why. □ □ Prostate: Prostate Biopsy □ Prostate: Prostate	☐ Breast: Mastectomy (left breast)	☐ Ovaries: Tuba	I Ligation	☐ Blistering Sunburns			
Why:	☐ Breast: Mastectomy (right breast)	☐ Pancreas: Par	ncreatectomy	☐ Dry Skin			
Rectum: APR Abdominal Perineal Resection	☐ Colon: Colectomy	☐ Prostate: Pros	tate Biopsy	□ Eczema			
Gallbladder: Cholecystectomy Rectum: Low Anterior Resection Melanoma Poisson ky Precancerous Moles Pre	Why:	☐ Prostate: Pros	statectomy	☐ Flaking or Itchy Scalp			
Heart: Biological Valve Replacement	☐ Colon: Colostomy	☐ Rectum: APR	Abdominal Perineal Resection	☐ Hay Fever/Allergies			
Heart: Coronary Artery Bypass	☐ Gallbladder: Cholecystectomy	☐ Rectum: Low	Anterior Resection	☐ Melanoma			
Heart: Heart: Heart: Heart: Angloplasty: Stent Replacement Skin: Skin: Skin: Squamous Cell Carcinoma Squamous Cell Skin Cancer Squamous Cell Skin: Cancer Squamous Cell Skin: Cancer Squamous Cell Skin: Cancer Other Other None None Other None Other None None Other None Other None Other None None Other None	☐ Heart: Biological Valve Replacement	☐ Skin: Basal Ce	ell Carcinoma	☐ Poison Ivy			
Heart: Mechanical Valve Replacement Skin: Squamous Cell Carcinoma Squamous Cell Skin Cancer Other Ot	☐ Heart: Coronary Artery Bypass	☐ Skin: Melanon	☐ Precancerous Moles				
Heart: PTCA Angioplasty: Stent Placement Splene: Splenectormy Other None None Other None None Other None Other None N	☐ Heart: Heart Transplant	☐ Skin: Skin Bio	psy	□ Psoriasis			
□ Joint Replacement: Hip (left) □ Joint Replacement: Hip (right) □ Joint Replacement: Knee (left) □ Joint Replacement: Knee (left) □ Joint Replacement: Knee (left) □ Joint Replacement: Knee (right) □ Joint Replacement: Knee (right) □ Kidney: Kidney Biopsy □ Kidney: Kidney Stone Removal □ Kidney: Kidney Stone Removal □ Kidney: Nephrectomy □ Kidney: Nephrectomy □ Kidney: Nephrectomy □ Ves □ No □ Replacement: Knee (right) □ None □ Other	☐ Heart: Mechanical Valve Replacement	☐ Skin: Squamo	us Cell Carcinoma	☐ Squamous Cell Skin Cancer			
□ Joint Replacement: Hip (right) □ Joint Replacement: Knee (left) □ Joint Replacement: Knee (left) □ Joint Replacement: Knee (right) □ Kidney: Kidney Biopsy □ Kidney: Kidney Stone Removal □ Kidney: Kidney Transplant □ Kidney: Nephrectomy □ Kidney: Nephrectomy □ Kidney: Nephrectomy □ Ridney: Nephrectomy □ Ridney: Nephrectomy □ Ridney: Nephrectomy □ Previous history of melanoma? □ Previous history of poyou was a tanning salon? □ Previous history of pregnancies/births (list years) □ No Alcohol Use □ Less Than 1 drink/day □ No Alcohol Use □ Less Than 1 drink/day □ 3 or more drinks/day □ 3 or more drinks/day □ 3 or more drinks/day □ 3 or more drinks in 1 day? □ Patients over 65 and all female patients: □ Have you received your pneumonia vaccination? □ President over 65 and all female patients: □ How many times in the past year have you had 4 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? □ Patients over 65 and all female patients: □ How many times in the past year have you had 4 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? □ Patients over 65 and all female patients: □ No Previous history of melanoma? □ Previous history of melanoma? □ Previous history of melanoma? □ Previous history of pregnancies/births (list years) □ No Alcohol Use □ No	☐ Heart: PTCA Angioplasty: Stent Placement	☐ Spleen: Splen	ectomy	□ Other			
Use: Use: Use: Use: Use: Use: Use: Use:	☐ Joint Replacement: Hip (left)	☐ Testicles: Orc	hiectomy	□ None			
□ Joint Replacement: Knee (right) □ Kidney: Kidney Biopsy □ Kidney: Kidney Stone Removal □ Kidney: Kidney Transplant □ Kidney: Nephrectomy □ Kidney: Nephrectomy □ Vas □ No Fyes, what SPF? □ 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) □ Current every day smoker/tobacco user (quit date) □ Former every day smoker/tobacco user (quit date) □ Pormer every day smoker/tobacco user (quit date) □ Tomer every day smoker/tobacco user (quit date) □ Tomer every day smoker/tobacco user (quit date) □ Salor	☐ Joint Replacement: Hip (right)	□Uterus: Hyster	ectomy				
Courrent every day smoker/tobacco user (quit date) No Alcohol Use Less Than 1 drink/day No Alcohol Use Less Than 2 drinks/day No Alcohol Use Less Than 2 drinks/day No Alcohol Use Less Than 4 drinks/day No Alcohol Use Less Than 5 drinks/day No Alcohol Use Less Than 6 drinks/day No Alcohol Use Less Than 1 drink/day No Alcohol Use Less Than 1 drinks/day No Alcohol Use No Alcohol Us	☐ Joint Replacement: Knee (left)	Why:		Have you ever tested po	sitive for TB?	☐ Yes ☐ No	
Kidney: Kidney Stone Removal Kidney: Kidney Stone Removal Kidney: Kidney Stone Removal Kidney: Kidney Transplant Fi yes, what SPF? 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) Tobacco Use:	☐ Joint Replacement: Knee (right)	☐ None		D b familio bi		D.V D.N.	
Kidney: Kidney Transplant Yes No If yes, what SPF? Do you wear sunscreen? Yes No If yes, what SPF? Do you use a tanning salon? Yes No Are you currently pregnant? Yes No Are you currently pregnant? Yes No Previous history of pregnancies/births (list years) Yes No Alcohol Use Start date) Start date Start date) Start date Start date) Start date Start date) Start date) Start da	☐ Kidney: Kidney Biopsy	Other			-		
Kidney: Ridney Transplant If yes, what SPF? Do you use a tanning salon? Yes No	☐ Kidney: Kidney Stone Removal			-			
No you use a tanning salon? Yes No	☐ Kidney: Kidney Transplant					☐ Yes ☐ No	
Are you currently pregnant?	☐ Kidney: Nephrectomy			-			
Social History Tobacco Use:				Do you use a tanning sa	aion?	☐ Yes ☐ No	
Social History Tobacco Use:				Are you currently pregr	ant?	☐ Yes ☐ No	
Current every day smoker/tobacco user (start date) No Alcohol Use Less Than 1 drink/day 1-2 drinks/day 1-2 drinks/day 3 or more drinks/day 3 or more drinks/day 1-2 drinks/d				Previous history of pregn	ancies/births (list years)		
Current every day smoker/tobacco user (start date) No Alcohol Use Less Than 1 drink/day 1-2 drinks/day 3 or more drinks/day 3 or more drinks/day 3 or more drinks/day 1-2 drinks/day 3 or more drinks/day 3 or more drinks/day 1-2 drinks/day 3 or more drinks/day 3 or more drinks/day 3 or more drinks/day 3 or more drinks/day 4 or more drinks in 1 day?			Social History				
□ Current every day smoker/tobacco user (start date) □ Former every day smoker/tobacco user (quit date) □ 1-2 drinks/day □ 1-2 drinks/day □ 3 or more drinks/day □ 3 or more drinks/day □ 3 or more drinks/day □ 4 least sunder 65: How many times in the past year have you had 5 or more drinks in 1 day? □ 1 least sunder 65 and all female patients: Have you received your pneumonia vaccination? □ Yes □ No Have you ever tested positive for TB?	Tobacco Use:		·				
Quit date) 3 or more drinks/day	☐ Current every day smoker/tobacco user						
Quit date) 3 or more drinks/day	(start date)						
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? 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? Patients over 65 and all female patients: How many times in the past year have you had 4 or more drinks in 1 day?	(quit date)						
Have you received your flu vaccination for the current year? Yes No Have you received your pneumonia vaccination? Yes No Have you exercised your pneumonia vaccination? Have you exercised positive for TB?	□ Never		3 of filore driftks/day				
Have you received your pneumonia vaccination? Have you ever tested positive for TB? Patients over 65 and all female patients: How many times in the past year have you had 4 or more drinks in 1 day?	Have you received your flu vaccination for the current year?						
Have you ever tested positive for TB?	Have you received your pneumonia vaccination?		Patients over 65 and all female patients: How many times in the past year have you had 4 or more drinks in 1 day?				
Yes No							

Review of Symptoms and Medications

Patient Name:				_ Date of Birth:		
REVIEW OF SYSTEMS HI	story or current	problem with any of the foll	owing? (Pleas	se check all that apply)		
Problems with bleeding	☐ Yes ☐ No	Rash/Hives	☐ Yes ☐ No	MRSA	☐ Yes ☐ No	
Problems with healing	☐ Yes ☐ No	Seizures	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	
Problems with scarring (hypertrophic or keloid)	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No	Currently pregnant or planning a pregnancy	☐ Yes ☐ No	
Abdominal Pain	☐ Yes ☐ No	Sleeplessness	☐ Yes ☐ No	Premedication prior to procedures	☐ Yes ☐ No	
Anxiety	☐ Yes ☐ No	Sore Throat	☐ Yes ☐ No	Rapid heartbeat with epinephrine	☐ Yes ☐ No	
Bloody Stool	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No	Ebola Risk: Fever >+100.4	☐ Yes ☐ No	
Bloody Urine	☐ Yes ☐ No	Unintentional Weight loss	☐ Yes ☐ No	West Africa: travel or contact	☐ Yes ☐ No	
Blurry Vision	☐ Yes ☐ No	Vaginal Candidiasis	☐ Yes ☐ No	Ebola Risk: contact w/ebola patient without		
Chest Pain	☐ Yes ☐ No	Wheezing	☐ Yes ☐ No	proper protective equipment within t	he last	
Cough	☐ Yes ☐ No	Red Eye	☐ Yes ☐ No	21 days 🖵 Yes 🖟		
Depression	☐ Yes ☐ No	Tearing	☐ Yes ☐ No	Ebola Risk: headaches, weakness, muscle pain		
Dizziness	☐ Yes ☐ No	Eye Pain	☐ Yes ☐ No	vomiting, diarrhea, abdominal pain,	and/or	
Fever or Chills	☐ Yes ☐ No	Uncontrolled Blood Pressure	☐ Yes ☐ No	hemorrhage	☐ Yes ☐ No	
Grey Discoloration of Skin	☐ Yes ☐ No	Elevated Blood Sugar	☐ Yes ☐ No			
Hay Fever	☐ Yes ☐ No			Prostate Medications	☐ Yes ☐ No	
Headaches	☐ Yes ☐ No	Allergy to Adhesive	☐ Yes ☐ No	Transplant	☐ Yes ☐ No	
Immunosuppression	☐ Yes ☐ No	Allergy to Lidocaine	☐ Yes ☐ No	HIV	☐ Yes ☐ No	
Joint Aches	☐ Yes ☐ No	Allergy to topical antibiotic ointments				
Menstrual Changes	☐ Yes ☐ No	Artificial Heart Valves	☐ Yes ☐ No			
Muscle Weakness	☐ Yes ☐ No	Artificial Joints in the last 2 yrs	☐ Yes ☐ No			
Neck Stiffness	☐ Yes ☐ No	Blood Thinners	☐ Yes ☐ No			
	☐ Yes ☐ No	Defibrillator	☐ Yes ☐ No			
Night Sweats				innere?		
	Are yo	u currently taking any of the fo	nowing blood th	mmers:		
□ NONE □ Aspirin □	Cilostazol (Pletal)	☐ Coumadin (Warfarin) ☐	Dipyridamole (Ag	grenox) 🛘 Effient 🗘 Eliquis		
•	Cilostazol (Pletal) ⊐ Plavix (Clopidogre	, ,		grenox)		
•	, ,	, ,		, ,		
□ Pentoxifylline (Trental)	⊐ Plavix (Clopidogre	el) □ Pradaxa □ Ticagrelor (Brilinta) 🗆 T	, ,	lements	
□ Pentoxifylline (Trental)	⊐ Plavix (Clopidogre	el) □ Pradaxa □ Ticagrelor (Brilinta) 🗆 T	iclodipin (Ticlid) □ Xarelto	<u>lements</u>	
□ Pentoxifylline (Trental) Medications – complete list	□ Plavix (Clopidogre	el) □ Pradaxa □ Ticagrelor (eparate list – must include all pr	Brilinta) 🔲 T	iclodipin (Ticlid) □ Xarelto		
□ Pentoxifylline (Trental)	□ Plavix (Clopidogre	el) □ Pradaxa □ Ticagrelor (Brilinta) 🗆 T	iclodipin (Ticlid) □ Xarelto		
□ Pentoxifylline (Trental) Medications – complete list	□ Plavix (Clopidogre	el) □ Pradaxa □ Ticagrelor (eparate list – must include all pr	Brilinta) 🔲 T	iclodipin (Ticlid) □ Xarelto		
□ Pentoxifylline (Trental) Medications – complete list	□ Plavix (Clopidogre	el) □ Pradaxa □ Ticagrelor (eparate list – must include all pr	Brilinta) 🔲 T	iclodipin (Ticlid) □ Xarelto		
□ Pentoxifylline (Trental) Medications – complete list	□ Plavix (Clopidogre	el) □ Pradaxa □ Ticagrelor (eparate list – must include all pr	Brilinta) 🔲 T	iclodipin (Ticlid) □ Xarelto		
□ Pentoxifylline (Trental) Medications – complete list	□ Plavix (Clopidogre	el) □ Pradaxa □ Ticagrelor (eparate list – must include all pr	Brilinta) 🔲 T	iclodipin (Ticlid) □ Xarelto		
□ Pentoxifylline (Trental) Medications – complete list	□ Plavix (Clopidogre	el) □ Pradaxa □ Ticagrelor (eparate list – must include all pr	Brilinta) 🔲 T	iclodipin (Ticlid) □ Xarelto		
□ Pentoxifylline (Trental) Medications – complete list	□ Plavix (Clopidogre	el) □ Pradaxa □ Ticagrelor (eparate list – must include all pr	Brilinta) 🔲 T	iclodipin (Ticlid) □ Xarelto		
□ Pentoxifylline (Trental) Medications – complete list	□ Plavix (Clopidogre	el) □ Pradaxa □ Ticagrelor (eparate list – must include all pr	Brilinta) 🔲 T	iclodipin (Ticlid) □ Xarelto		
□ Pentoxifylline (Trental) Medications – complete list	□ Plavix (Clopidogre	el) □ Pradaxa □ Ticagrelor (eparate list – must include all pr	Brilinta) 🔲 T	iclodipin (Ticlid) □ Xarelto		
□ Pentoxifylline (Trental) Medications – complete list	□ Plavix (Clopidogre	el) □ Pradaxa □ Ticagrelor (eparate list – must include all pr	Brilinta) 🔲 T	iclodipin (Ticlid) □ Xarelto		
□ Pentoxifylline (Trental) Medications – complete list	□ Plavix (Clopidogre	el) □ Pradaxa □ Ticagrelor (eparate list – must include all pr	Brilinta) 🔲 T	iclodipin (Ticlid) □ Xarelto		
□ Pentoxifylline (Trental) Medications – complete list Medication Name	□ Plavix (Clopidogre	eparate list – must include all properties of the properties of th	Brilinta) 🔲 T	iclodipin (Ticlid) □ Xarelto		
Pentoxifylline (Trental) Medications – complete list Medication Name Latex Allergy? □ Yes □ No	□ Plavix (Clopidogre	eparate list – must include all properties of the properties of th	Brilinta) 🔲 T	iclodipin (Ticlid) □ Xarelto		
Pentoxifylline (Trental) Medications – complete list Medication Name Latex Allergy? □ Yes □ No	□ Plavix (Clopidogre	eparate list – must include all properties of the properties of th	Brilinta) 🔲 T	iclodipin (Ticlid) □ Xarelto		
Medications – complete list Medication Name Medication Name	□ Plavix (Clopidogre	eparate list – must include all properties of the properties of th	Brilinta) 🔲 T	iclodipin (Ticlid) □ Xarelto		

Signature of Responsible Party/Date