PATIENT REGISTRATION FORM

Brett M. Coldiron, M.D.

Welcome to the SKIN CANCER CENTER

PATIENT INFORMATION

PATIENT NAME				REFERRING DOCTOR NAME	
ADDRESS (STREET, APT. NO)				EMPLOYER NAME	TELEPHONE (WORK)
CITY, STATE, ZIP				EMPLOYMENT ADDRESS CITY, STATE, ZIP	
TELEPHONE (DAYTIME)		TELEPHONE (HOME)		IN CASE OF AN EMERGENCY CONTACT	
DATE OF BIRTH	AGE	SEX	SOCIAL SECURITY NUMBER	SPOUSE NAME (LAST, FIRST)	TELEPHONE (WORK)
EMAIL ADDRESS				WOULD YOU LIKE TO BE ADDED TO OUR MAILING LIST? ☐ YES ☐ NO	

IN THE EVENT WE ARE UNABLE TO CONTACT YOU IS THERE SOMEONE WE CAN LEAVE TEST RESULTS WITH

NAME _____ RELATION _____ NUMBER _____

NAME _____ RELATION _____ NUMBER _____

NAME _____ RELATION _____ NUMBER _____

☐ **INITIAL THIS BOX IF WE CAN LEAVE A VOICE MESSAGE CONCERNING YOUR BIOPSY RESULTS.**

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT, NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE REGARDLESS OF INSURANCE COVERAGE. WE DO NOT HONOR DNR (DO NOT RESUSCITATE) OR LIVING WILL REQUESTS.

INSURANCE AUTHORIZATION AND ASSIGNMENT (PLEASE READ AND SIGN)

I HEREBY AUTHORIZE THE PHYSICIAN TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENT AND I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE POLICY AND YOU WILL BE RESPONSIBLE FOR ANY CHARGES AFTER INSURANCE HAS MADE PAYMENT AND ADJUSTMENTS ARE MADE. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE, INCLUDING BUT NOT LIMITED TO AMBULATORY SURGICAL ROOM FEES. I AGREE TO PAY ALL BALANCE DUE IN FULL WITHIN TEN DAYS OF STATEMENT, UNLESS ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. I UNDERSTAND THAT A COPY OF THIS OFFICE PRIVACY PRACTICES IS AVAILABLE UPON REQUEST AND IS POSTED ON WAITING ROOM BULLETIN BOARD.

SIGNATURE _____ DATE _____

PATIENT PROFILE SHEET

Please fill out the following information so that we can better care for you. If you have trouble, we can help you fill it out.

Patient name _____

1. Which doctor sent or referred you to us? _____

   Who is your regular dermatologist? _____
2. What is your age? _____
3. What is your occupation? If retired, tell what you did before you retired. _____
4. Do you have skin cancer? If no, proceed to question #9. ☐ Yes ☐ No
5. If yes, where, and for how long? _____
6. If yes, has this been treated before (not counting the biopsy)? If yes, how was it treated?

   (scraped and burned, frozen, x-rayed, cut out) _____
7. When your skin cancer was last biopsied? _____
8. Was it a basal cell carcinoma or squamous cell carcinoma or other?

   Please let here _____
9. What is your past medical history? For example do you have heart trouble? Diabetes? Artificial joints?

   Artificial heart valve? High blood pressure? Organ transplant? _____

   _____
10. Do you have any drug/medication allergies? If so, list _____

    _____
11. What medicines are you currently taking? _____

    _____
12. Do you take aspirin or arthritis medicine? ☐ Yes ☐ No
13. Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? _____
14. Did you ever recieve radiation treatment for acne? _____
15. Have you read the booklet about Mohs surgery? ☐ Yes ☐ No
16. Have you read the insert “About Dr. Coldiron”? ☐ Yes ☐ No
17. Have you ever had any plastic surgery done? ☐ Yes ☐ No

    If yes, what? _____
18. Do you have a family history of skin cancer? ☐ Yes ☐ No

Completed by _____ Date _____

Reviewed by _____ and _____

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