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)

Medical Information Release (Privacy Policies are located at the reception desk)	
Cell Phone: ( )	May we leave a detailed message regarding test results, appointments, and/or billing? ❑ Yes ❑ No May we leave a message for you to return our call? ❑ Yes ❑ No
Home Phone: ( )	May we leave a detailed message regarding test results, appointments, and/or billing? ❑ Yes ❑ No May we leave a message for you to return our call? ❑ Yes ❑ No
Work Phone: ( )	May we leave a detailed message regarding test results, appointments, and/or billing? ❑ Yes ❑ No May we leave a message for you to return our call? ❑ Yes ❑ No
Circle your preferred contact method	**Cell Home Work Email**

***IF you would like text messages sent to your cell phone for appointment reminders please text: **DSWO** to 622622

If you are not available may we leave a message with another person? If yes, please state below:

Name/Relationship ____ Phone ______________________

Email Address:

Emergency Contact:

Name/Relationship ____ Phone _______________________

Pharmacy: *our office does electronic prescriptions – 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 ________________

Signature of Responsible Party/Date ____

Dermatologists of Southwest Ohio and Dermatologists of Greater Columbus Financial Policy

Thank you for choosing Dermatologists of Greater Columbus. The following is our financial policy. Please review the policy, initial where indicated, 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 from preventing 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.

Initial _________

Missed appointments/Cancellations: We request 24 hour advanced notification of cancellations and reschedules. We try to notify all patient 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 cancellations can results in dismissal from our practice.

Initial _________

Insurance: Our practice is contracted with most commercial insurances and Medicare. We do not accept 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 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 prior to, or at the time of service. Patient is responsible for payment of services rendered in the event they incorrect insurance information was provided at the time of service.

Available forms of payment include: cash, check, MasterCard, and Visa. **We Do Not accept Discover or American Express.**

Initial _________

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

Initial _________

Lab Fee: Dermatologists of Greater Columbus and Dermatologists of Southwest Ohio use an outside laboratory for pathology services. The lab will bill you directly for these services.

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 charges. 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.

Initial _________

My Signature below indicates that I have read and agree to the above written financial policy of Dermatologists of Greater Columbus.

Signature of Responsible Party/Date ____

Insurance Information:

Does your insurance require a referral? ❑ Yes ❑ No If yes please list all physician information on page 1

Primary Insurance

Insurance Name/Phone: ____

Insurance Effective Date ____________

Subscriber's Policy Number _______________________________ Group No.______________ Specialty Co-Pay $_______

Subscriber's Name and Address (if different from patient) ____

Subscriber's Date of Birth __________________ Subscriber's Social Security Number __________________

Secondary Insurance

Insurance (Secondary) ________________________________ Insurance Effective Date ____________ Insurance Phone: ______________________

Subscriber's Policy Number ________________________ Group No.______________ Specialty Co-Pay $_______

Subscriber's Name and Address______________________ Subscriber's Date of Birth ________________

Subscriber's SSN _____________________

Person Responsible for Payment if Other than Patient

Billing Name _____________________________ Social Security Number _______________________________

Date of Birth ________________________________

Phone Number _______________________________ Relationship to Patient _________________________

Employer ____

Address ____

Recent Insurance policy changes and the popularity of high deductible plans have increased the number of bills and balances to patients. If you have not met your deductible for your plan year, please expect a bill from our office. Per our insurance contracts we are unable to make adjustments to any outstanding balance.

Signature of Responsible Party/Date ____

PATIENT INFORMATION

Name:	Date of Birth:	Account #:

Latex allergy?	Any drug allergies?	If yes, list any drugs you are allergic to:
❑ Yes ❑ No	❑ Yes ❑ No	

MEDICAL SYMPTOMS Please check all the apply

❑ Anxiety	❑ Colon Cancer	❑ Hepatitis	❑ Lymphoma
❑ Arthritis	❑ COPD	❑ Hypertension	❑ Prostate cancer
❑ Asthma	❑ Coronary artery disease	❑ HIV/AIDS	❑ Radiation Treatment
❑ Atrial fibrillation	❑ Depression	❑ Hypercholesterolemia	❑ Seizures
❑ Bone Marrow Transplant	❑ Diabetes	❑ Hyperthyroidism	❑ Stroke
❑ BPH (benign prostatic hyperplasia)	❑ End Stage Renal Disease	❑ Hypothyroidism	❑ Other
❑ Breast Cancer	❑ GERD	❑ Leukemia	________________________________ ___________________________
	❑ Hearing Loss	❑ Lung cancer	❑ None

Have you had any surgeries on the following Organs Please check all the apply

❑ Appendix: (appendectomy)	❑ Joint Replacement: Knee (left)	❑ Uterus: (hysterectomy): Fibroids
❑ Bladder: (cystectomy)	❑ Joint Replacement: Knee (right)	❑ Uterus: (hysterectomy): Uterine Cancer
❑ Breast: Breast Biopsy	❑ Kidney: Kidney Biopsy	❑ Uterus: (hysterectomy): Cervical Cancer
❑ Breast: Lumpectomy (both breasts)	❑ Kidney: Kidney Stone Removal	❑ Other ________________________________
❑ Breast: Lumpectomy (left breast)	❑ Kidney: Kidney Transplant	❑ None
❑ Breast: Lumpectomy (right breast)	❑ Liver: Hepatectomy	
❑ Breast: Mastectomy (both breasts)	❑ Liver: Liver Transplant	
❑ Breast: Mastectomy (left breasts)	❑ Liver: Shunt	
❑ Breast: Mastectomy (right breasts)	❑ Ovaries: (oophorectomy): Endometrosis	
❑ Colon (colectomy): Colon Cancer Resection	❑ Ovaries: (oophorectomy): Ovarian Cancer	
❑ Colon (Colectomy): Diverticulitis	❑ Ovaries: Tubal Ligation	
❑ Colon (Colectomy): Inflammatory Bowel	❑ Pancreas: Pancreatectomy	
❑ Colon: Colostomy	❑ Prostate: (prostatectomy): Prostate Biopsy	
❑ Gallbladder: (cholecystectomy)	❑ Prostate: (prostatectomy): Prostate Cancer	
❑ Heart: Biological Valve Replacement	❑ Prostate: (prostatectomy): TURP (transurethral resection)	
❑ Heart: Coronary Artery Bypass	❑ Rectum: APR (abdominal perineal resection)	
❑ Heart: Heart Transplant	❑ Rectum: Low anterior resection	
❑ Heart: Mechanical Valve Replacement	❑ Skin: Basal Cell Carcinoma	
❑ Heart: PTCA (angioplasty)	❑ Skin: Melanoma	
❑ Joint Replacement: Hip (both)	❑ Skin: Skin Biopsy	
❑ Joint Replacement: Hip (left)	❑ Skin: Squamous Cell Carcinoma	
❑ Joint Replacement: Hip (right)	❑ Spleen: (splenectomy)	
❑ Joint Replacement: Knee (both)	❑ Testicles: (orchiectomy)	

Have you had any of the following conditions:

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

Do you wear sunscreen? ❑ Yes ❑ No If Yes, what SPF?	Are you currently pregnant? ❑ Yes ❑ No Previous history of pregnancies/births (list years)
Do you tan in a tanning salon? ❑ Yes ❑ No	Do you have a family history of melanoma? ❑ Yes ❑ No If yes, which relative?

Signature of Responsible Party/Date ____

■ **Are you currently taking any of the following?** ❑ Coumadin/Wafarin ❑ Pradaxa ❑ Effient ❑ Plavix ❑ Aspirin

Medications (list all prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary supplements as well as name/dosage/freq/route)

Medication Name	Dosage	Frequency	Route

SOCIAL HISTORY

Tobacco Products Use?
❑ Current every day smoker
❑ Former every day smoker
❑ Never

Date Started/Quit

____

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

Alcohol:
❑None
❑ Less than 1 drink/day
❑ 1-2 drinks daily
❑ 3 or more drinks daily

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women (or any adult over the age of 65)?
Please provide the approximate number in the space provided

____

Have you received your flu vaccination?

❑ Yes ❑ No

What year?

Have you received your pneumonia vaccination?

❑ Yes ❑ No

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
(if yes, indicate year_____________)
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 antiobiotic ointments ❑ Yes ❑ No
Artificial heart valves ❑ Yes ❑ No
Artificial joints in the last 2 yrs ❑ Yes ❑ No
Blood thinners ❑ 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

Signature of Responsible Party/Date ____