

Patient Name: _____ **Birthdate:** _____

Preferred Pharmacy: _____

Pharmacy Phone #: _____ **Pharmacy City/Zip:** _____

MEDICAL HISTORY: *Select the following medical conditions you currently have:*

- | | |
|---|---|
| <input type="checkbox"/> NONE | <input type="checkbox"/> Human Immunodeficiency virus |
| <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Hypercholesterolemia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Inflammatory disease of the liver |
| <input type="checkbox"/> Cerebrovascular accident | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Chronic obstructive lung disease | <input type="checkbox"/> Malignant lymphoma (clinical) |
| <input type="checkbox"/> Coronary arteriosclerosis | <input type="checkbox"/> Malignant tumor of lung |
| <input type="checkbox"/> Depressive disorder | <input type="checkbox"/> Malignant tumor of breast |
| <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Malignant tumor of colon |
| <input type="checkbox"/> Elevated Blood Pressure | <input type="checkbox"/> Malignant tumor of prostate |
| <input type="checkbox"/> End-stage renal disease | <input type="checkbox"/> Radiation therapy treatment management |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Transplantation of bone marrow |
| <input type="checkbox"/> Gastro-esophageal reflux disease | <input type="checkbox"/> Other |
| <input type="checkbox"/> Hearing loss | |

SOCIAL HISTORY:

Do you smoke?

- I do not smoke
- I smoke/vape daily
(Brochure provided by MOHS staff. ☐)

Do you have an Advanced Care Plan?

- I have a current Advance Care Plan. *(Copy provided for our office. ☐)*
- I need a new ACP form. *(ACP forms provided by MOHS staff. ☐)*

Do you feel depressed?

*Do you feel nervous, anxious, or on edge?
Not being able to stop or control worrying?
Feeling down, depressed or hopeless?
Little interest or pleasure in doing things?*

- | | |
|---------------------------------|---|
| <input type="checkbox"/> Rarely | <input type="checkbox"/> Nearly every day |
| <input type="checkbox"/> Rarely | <input type="checkbox"/> Nearly every day |
| <input type="checkbox"/> Rarely | <input type="checkbox"/> Nearly every day |
| <input type="checkbox"/> Rarely | <input type="checkbox"/> Nearly every day |
- (Brochure provided by MOHS staff. ☐)*

PAST SURGERIES: Have you had any surgeries on the following organs?

- | | |
|---|--|
| <input type="checkbox"/> NONE | <input type="checkbox"/> History of colectomy |
| <input type="checkbox"/> Bilateral replacement of knee joints | <input type="checkbox"/> History of tissue graft heart valve replacement |
| <input type="checkbox"/> Biopsy of breast | <input type="checkbox"/> Mechanical heart valve replacement |
| <input type="checkbox"/> Biopsy of prostate | <input type="checkbox"/> Surgical biopsy of skin |
| <input type="checkbox"/> Coronary artery bypass graft | <input type="checkbox"/> Total replacement of left hip joint |
| <input type="checkbox"/> Entire transplanted kidney | <input type="checkbox"/> Total replacement of right hip joint |
| <input type="checkbox"/> Excision of basal cell carcinoma | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Excision of melanoma | |
| <input type="checkbox"/> Excision of squamous cell carcinoma | |

MEDICAL CONDITIONS: Have you had any of the following:

- | | |
|---|---|
| <input type="checkbox"/> NONE | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Malignant melanoma |
| <input type="checkbox"/> Actinic Keratosis | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Basal cell carcinoma of skin | <input type="checkbox"/> Squamous cell carcinoma |
| <input type="checkbox"/> Contact dermatitis due to poison ivy | <input type="checkbox"/> Sunburn of second degree |
| <input type="checkbox"/> Dysplastic naevus of skin | <input type="checkbox"/> Other skin problems: _____ |

Do you wear sunscreen? No Yes - *If yes, what SPF?* _____

Do you tan in a tanning salon? No Yes

FAMILY HISTORY OF MELANOMAS:

- | | | |
|---|--|---------------------------------|
| <input type="checkbox"/> NO family history of melanomas | <input type="checkbox"/> Sister | <input type="checkbox"/> Uncle |
| <input type="checkbox"/> Mother | <input type="checkbox"/> Brother | <input type="checkbox"/> Aunt |
| <input type="checkbox"/> Father | <input type="checkbox"/> Daughter | <input type="checkbox"/> Nephew |
| <input type="checkbox"/> Grandmother (M/P) | <input type="checkbox"/> Son | <input type="checkbox"/> Niece |
| <input type="checkbox"/> Grandfather (M/P) | <input type="checkbox"/> Grandson | |
| | <input type="checkbox"/> Granddaughter | |

MEDICATIONS AND ALLERGIES:

Please list ALL your **allergies** and reactions:

ALLERGEN (list all medications, anesthetics, latex, adhesives, etc.)	REACTION (describe reaction: shock, rash, shortness of breath, etc.)

If you need additional space, please write on the bottom of this form.

Please list ALL your **prescribed medications** and dosages.

NAME OF MEDICATION	DOSAGE	FREQUENCY	REASON

If you need additional space, please write on the bottom of this form.

REVIEW OF SYSTEMS: Mark **Yes** indicating symptoms you are **CURRENTLY** experiencing – Mark **No** confirming you are not experiencing any symptoms:

SYMPTOM	YES	NO	SYMPTOM	YES	NO
<i>Alerts: symptom</i>			<i>Currently pregnant or planning a pregnancy</i>		
<i>Fever or chills</i>			<i>Headaches</i>		
<i>Hay fever</i>			<i>Seizures</i>		
<i>Hearing aid or cochlear implant</i>			<i>Anxiety</i>		
<i>Blurry vision</i>			<i>Dementia</i>		
<i>Cough</i>			<i>Depression</i>		
<i>Shortness of breath</i>			<i>Problems with scarring (hypertrophic or keloid)</i>		
<i>Wheezing</i>			<i>Joint aches</i>		
<i>Oxygen use</i>			<i>Muscle weakness</i>		
<i>Chest pain</i>			<i>Neck stiffness</i>		
<i>Artificial heart valve</i>			<i>Cancer chemotherapy</i> <i>Or Chronic Lymphocytic Leukemia</i>		
<i>Defibrillator</i>			<i>Immunosuppression</i>		
<i>Pacemaker</i>			<i>Dialysis</i>		
<i>Rapid heartbeat with epinephrine</i>			<i>Blood thinners</i>		
<i>Organ transplant</i>			<i>Problems with bleeding</i>		
<i>Abdominal pain</i>			<i>Problems with healing</i>		
<i>Bloody stools</i>			<i>MRSA</i>		
<i>Bloody urine</i>			<i>Allergy to lidocaine</i>		
<i>Night sweats</i>			<i>Allergy to topical antibiotic ointments</i>		
<i>Unintentional weight loss</i>			<i>History of staph infections</i>		
<i>Thyroid problems</i>			<i>Premedication prior to procedure</i>		
<i>Fibromyalgia</i>					

Legal Name: _____ Birthdate: _____ SS#: _____ (For insurance)
Last First M.I.

Home Address: _____
Street # Street Name Apt City State Zip Code

Billing Address: _____

Email Address: _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

Prefer to be called (aka): _____ Military Rank/Rate: _____ Active Duty or Retired Military? _____

Sex: Male or Female Marital Status: _____ Spouse's Name: _____

Patient's Occupation: _____ Patient's Employer: _____

Referring Physician: _____ Addr: _____ Phone: _____

Primary Care Physician: _____ Addr: _____ Phone: _____

Other Physician: _____ Addr: _____ Phone: _____

How did you hear about Dr. John Boyer/Dr. Patrick Ellison/Dr. Westley Mori? Other physician _____ Friend or relative _____ Other _____

Is this visit(s) related to worker's compensation? _____ YES _____ NO

PARENT OR RESPONSIBLE PARTY (If under 18 or different from Patient)

Name: _____ SS# _____
Last First M.I.

Address: _____
City State Zip

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

Date of Birth ____/____/____ Sex: Male or Female Military Rank/Rate: _____ Active Duty or Retired?

INSURANCE INFORMATION: Please present insurance card and photo ID at time of check-in. All copayments are due at time of service.

Primary:	Secondary:	Tertiary:
Name of Subscriber: _____	Name of Subscriber: _____	Name of Subscriber: _____
Relation to Patient: _____	Relation to Patient: _____	Relation to Patient: _____
Subscriber's Birthdate: _____	Subscriber's Birthdate: _____	Subscriber's Birthdate: _____
Insured's Member #: _____	Insured's Member #: _____	Insured's Member #: _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process claims insurance applications and prescriptions.

I authorize payment of medical benefits to the physician.

X _____ / / _____
Signature of Patient or Responsible Party **Date**

FINANCIAL POLICY

Thank you for choosing us. We appreciate your trust in us and the opportunity to serve you. As part of our practice, we try to offer efficient and helpful billing services. To this end, we ask you to read the following statement of our financial policy. Please sign it prior to any treatment. If you'd like to obtain a copy of this financial policy, please request a copy from the front office.

- **Co-pays and deductibles are due at the time of service.**
- **Payment for non-covered or cosmetic procedures is due at the time of service.**
- **We accept cash, checks, VISA and Mastercard credit cards.**
- **Patients who do not have insurance are required to pay in full at the time of service. If you are not able to pay in full, please call our office to make payment arrangements.**

PARTICIPATING PLANS

We will be happy to bill insurance plans we participate in. Once we receive correct payment, we will make our contractual adjustment and send you a bill for the balance due.

NON-PARTICIPATING PLANS

As a courtesy to you we will bill your insurance carrier if you provide us with complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account within 30 days, the balance will be assessed to you for payment. You should remit payment within 30 days or contact your insurance to check the status of the claim. Please notify us immediately upon contacting your insurance company or if there is anything we can do to help settle this claim. You are responsible for payment regardless of any non-participating insurance company's arbitrary determination of usual and customary rates. **We DO NOT accept workers' compensation.**

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best of care for our patients. Our charges are within the usual and customary charges for our specialty in our area.

PAST DUE BILLS

Please note that if your balance is unpaid for 90 days, your account will be eligible for assignment to a collection agency without further notification.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read, understand, and agree to this Financial Policy.

X _____

Patient/Responsible Party

_____ **Date**

**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM**

The signature below acknowledges that I, _____, have read and/or received a copy of

Patient Name

Dr. John D. Boyer, Dr. Patrick Ellison, and Dr. Westley Mori's Notice of Privacy Practices.

X _____
Patient or Guardian Signature

Date

PATIENT CONTACT AUTHORIZATION

Due to the HIPAA Privacy Act, we are only authorized to contact or speak to the individuals listed below regarding your medical information/record, appointments and scheduling, treatments, and test results.

You may:

- Contact me or leave a message at:** _____ (Home #)

_____ (Work #)
_____ (cell/pager #)

If I am unable to be reached, you may leave a message or speak with:

Name Relationship to Patient Phone Number

Name Relationship to Patient Phone Number

Name Relationship to Patient Phone Number

In case of a medical emergency, who should be notified?

Name: _____ **Relationship:** _____ **Phone:** _____

Do you have voicemail? Yes ___ No ___ **If so, may we leave you voicemail messages from this office?** Yes ___ No ___

X _____
Patient or Guardian Signature _____ **Date**