

PATIENT REGISTRATION FORM

PATIENT NAME:			
SSN:	OCCUPATION:	OCCUPATION:	
DATE OF BIRTH:	AGE:	SEX: M F	
ADDRESS:			
CITY:	STATE:	ZIP CODE:	
HOME PHONE:	CELL PHONE:	WORK PHONE:	
YOUR PREFERRED CONTACT (CIR	RCLE ONE): HOME WORK	CELL	
IS IT OK TO LEAVE A DETAILED N	1ESSAGE?* YES N	IO	
*MESSAGES WOULD INCLUDE LA	AB WORK, BIOPSY RESULTS, ETC.	/91 -	
EMAIL ADDRESS:			
MARITAL STATUS: S N	1 W		
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	CAN AMERICAN ASIAN [
	HISPANIC DECLINE		
*WE ARE REQUIRED TO COLLECT THIS DA	TA TO COMPLY WITH MEDICARE REQUIREMEN	ITS FOR ELECTRONIC MEDICAL RECORDS	
INI	CASE OF EMERGENCY PLEASE CONT	ACT	
NAME:	RELATIONSHIP:	PHONE:	
RESPONSIBLE PART	Y (PRIMARY INSURANCE CARD HOL	DER) INFORMATION	
NAME:	. (5	-	
ADDRESS:			
	CTATE.	ZIP CODE:	
CITY:	STATE:		
SSN:	DATE OF BIRTH:	SEX: M F	
PLEASE LIST ALL PERSONS P	ERMITTED TO SPEAK WITH REGARD	ING MEDICAL INFORMATION	
NAME:	RELATIONSHIP:	PHONE:	
NAME:	RELATIONSHIP:	PHONE:	

PATIENT REGISTRATION FORM

PATIENT NAME:				
	PHARMACY	INFORMATION		
MAIL ORDER:				
LOCAL PHARMACY:	<u> </u>	PHO	NE:	
ADDRESS:				
CITY:	STATE:		ZIP CODE:	
PRIMARY CARE DOCTOR:				
ADDRESS:		РНО	PHONE:	
CITY:	STATE:	. fea	ZIP CODE:	
REFERRING DOCTOR:				
ADDRESS:		PHO	NE:	
CITY:	STATE:	. 11	ZIP CODE:	
	OR PAYMENT OF BEN	EFITS/RELEASE OF	MEDICAL INFORMATION ALLIED DERMATOLOGY AND SKIN SURGERY,	
X SIGNATURE	DATE			
AUTHORIZATION F	OR USE AND DISCLOS	URE OF PROTECTE	D HEALTH INFORMATION	
Signing below permits ALLIED DERN treatment, payment, and health car (HIPAA) (Copy available upon reque	re operations in compliance v	RY, LLC to use and disclo with the Health Insuranc	se health information about you for e Portability and Accountability Act of 1996	
X SIGNATURE	DATE			
*FOR OFFICE USE ONLY INITIAL BELOW TO VERI	FY ALL INFORMATIO	ON IS CORRECT		
	The state of the s			



You are scheduled with either Dr. Allison Moosally or Dr. Justin Woodhouse to undergo Mohs Surgery;

MOHS Pre-Surgery Instructions:

- Please be sure to bring a driver for your trip home. You can experience unexpected swelling that may impact your ability to drive.
- Please shower before your appointment. Clean skin is important to minimize infection. Please do not use perfume or cologne prior to surgery.
- Plan to be in our office for at least 4-6 hours the day of your procedure, although the actual time may vary. It is helpful to bring reading material to pass the time. Most of the time is waiting for processing of the specimen removed.
- DO NOT plan your surgery close to any major events or vacations. You may have sutures for up to 2 weeks, or a complicated repair after your procedure that will prohibit traveling.
- Please provide a current list of your medications/allergies to the clinical staff.
- You SHOULD eat a good breakfast or lunch before your appointment.
- Your blood pressure must be controlled for your surgery. Please avoid excessive sodium, sugar and caffeine 2 days prior to your procedure.
- Please STOP ALL vitamin supplements if possible 2 weeks prior to your surgery. Many of them contribute to bleeding.
- Take ALL prescribed medications.
- DO NOT discontinue any prescribed blood thinners or aspirin for your surgery, unless approved by your doctor.
- For patients on Coumadin/Warfarin, INR levels must be checked 1-2 weeks prior to surgery.
- Alcohol increases bleeding and should be minimized for the day prior and after surgery.
- Smoking significantly impairs your skin's ability to heal and can prolong healing time, with increased risk for infection and abnormal scarring. Nicotine strangulates the tiny vessels supplying blood (nutrition and immune system) for the healing wound. If you smoke or use nicotine, we strongly recommend quitting or decreasing as much as possible prior to surgery and until sutures are removed.
- While we hope your procedure is small and uncomplicated, skin cancers can be aggressive and may result in large or complicated wounds that require a delay in reconstruction for optimal healing. You may need to schedule a separate appointment for reconstruction of the site, if indicated.

For more information, a video detailing the Mohs procedure is accessible by link at the bottom of the homepage of our website. Our website address is located at the bottom of this page.

www.alliedderm.com

(330) 665-0555 **:** (330) 665-0556

(216) 382-3806 **=** : (216) 382-6735

(440) 266-5500 **=**: (440) 266-5505

(330) 871-9300 **:** (330) 665-0556



HAVE YOU HAD ANY OF THE FOLLOWING SKIN CONDITIONS?

None -Acne -Actinic Keratosis -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

PLEASE CIRCLE YOUR ANSWERS TO THE QUESTIONS

TELASE CIRCLE TOOK ANSWERS TO THE QUESTIONS
BELOW:
Do you wear sunscreen? YES NO
If yes, what SPF?
Do you tan in a tanning salon? YES NO Do you have a family history of Melanoma? YES NO
If yes, which relative? Mother -Father -Sister -Brother -Daughter -Son -Uncle
Aunt -Nephew -Niece
Do you have a family history of Cancer? YES NO
If yes, which relative? Mother -Father -Sister -Brother -Daughter -Son -Uncle -Aunt-Nephew -Niece What type of Cancer?
Do you smoke? YES OR NO If yes, when did you start smoking? Quit?
you have been smoking?
Do you drink alcoholic beverages? YES OR NO If yes, how often? • Less than 1 drink a week YES OR NO • 1-2 drinks a day YES OR NO
 1-2drinks a day YES OR NO 3 or more drinks YES OR NO Do you have a living will? YES OR NO Have you had a Flu Vaccine YES OR NO/ Have you had Pneumonia Vaccine? YES OR NO
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PLEASE CIRCLE ANY OF THE FOLLOWING MEDICAL CONDITIONS THAT YOU CURRENTLY HAVE:

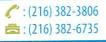
-None -Anxiety -Arthritis -Asthma -Atrial Fibrillation -Bone Marrow Transplantation -BPH - Breast Cancer - Colon Cancer -COPD - Coronary Artery Disease -Depression -Diabetes -End Stage Renal Disease -GERD -Hearing Loss -Hepatitis -Hypertension-HIV-AIDS - Hypercholesterolemia -Hypothyroidism -Leukemia -Lung Cancer - Lymphoma -Prostate Cancer - Radiation Treatment -Seizures -Stroke

<u>PLEASE CIRCLE IF YOU HAVE HAD ANY SURGERIES ON</u> THE FOLLOWING ORGANS:

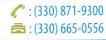
- None -Appendix (Appendectomy) -Bladder (Cystectomy)
- Breast Biopsy -Breast: Lumpectomy (Both/ Left/ Right) -Breast: Mastectomy (Both/ Left/ Right)
- Colon (Colectomy) Cancer Resection -Colon (Colectomy) Diverticulitis - Colon (Colectomy) Inflammatory Bowel Disease -Colon (Colostomy) -Gallbladder (Cholecystectomy)
- Heart: Biological Valve Replacement-Heart: Coronary Artery Bypass Surgery
- · Heart Transplant Heart: Mechanical Valve Replacement Heart: PTCA
- Joint Replacement: Hip (Both/ Left/ Right) -Joint Replacement: Knee (Both/ Left/ Right)
- Kidney: Kidney Biopsy -Kidney: Kidney Stone Removal Kidney: Kidney Transplant Kidney: Nephrectomy
- Liver: Hepatectomy -Liver: Liver Transplant Liver: Shunt -Ovaries (Oophorectomy): -- Endometriosis -Ovaries (Oophorectomy): Ovarian Cancer
- Ovaries (Oophorectomy): Ovarian Cyst -Ovaries: Tubal Ligation -Pancreas: Pancreatectomy
- Prostate (Prostatectomy): Prostate Biopsy -Prostate (Prostatectomy): Prostate Cancer
- Prostate (Prostatectomy):TURP -Rectum: APR -Rectum: Low Anterior Resection
- · Skin: Basal Cell Carcinoma
- Skin: Melanoma -Skin: Skin Biopsy -Skin: Squamous Cell Carcinoma -Spleen (Splenectomy)
- Testicles (Orchiectomy) -Uterus (Hysterectomy): Fibroids -Uterus (Hysterectomy): Uterine Cancer
- Uterus (Hysterectomy): Cervical Cancer

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PLEASE LIST YOUR MEDICATIONS BELOW:
PLEASE LIST ANY MEDICATION ALLERGIES YOU HAVE:

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