ALLIED DERMATOLOGY
AND SKIN SURGERY

PATIENT REGISTRATION FORM

PATIENT NAME:		
SSN:	**OCCUPATION:**	
DATE OF BIRTH:	**AGE:**	**SEX: M F**
ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
HOME PHONE:	**CELL PHONE:**	**WORK PHONE:**
YOUR PREFERRED CONTACT (CIRCLE ONE): HOME WORK CELL		
IS IT OK TO LEAVE A DETAILED MESSAGE?* YES_____ NO_____		
***MESSAGES WOULD INCLUDE LAB WORK, BIOPSY RESULTS, ETC.**		
EMAIL ADDRESS:		

MARITAL STATUS: S M W
***PRIMARY LANGUAGE: ENGLISH____ SPANISH____ OTHER____ DECLINE____**
***RACE: CAUCASIAN____ AFRICAN AMERICAN ____ ASIAN____ DECLINE____**
***ETHNICITY: NON-HISPANIC____ HISPANIC____ DECLINE____**
***WE ARE REQUIRED TO COLLECT THIS DATA TO COMPLY WITH MEDICARE REQUIREMENTS FOR ELECTRONIC MEDICAL RECORDS**

IN CASE OF EMERGENCY PLEASE CONTACT		
NAME:	**RELATIONSHIP:**	**PHONE:**

RESPONSIBLE PARTY (PRIMARY INSURANCE CARD HOLDER) INFORMATION		
NAME:		
ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
SSN:	**DATE OF BIRTH:**	**SEX: M F**

PLEASE LIST ALL PERSONS PERMITTED TO SPEAK WITH REGARDING MEDICAL INFORMATION		
NAME:	**RELATIONSHIP:**	**PHONE:**
NAME:	**RELATIONSHIP:**	**PHONE:**

FLIP OVER →

PATIENT REGISTRATION FORM

PATIENT NAME:

PHARMACY INFORMATION		
MAIL ORDER:		
LOCAL PHARMACY:		PHONE:
ADDRESS:		
CITY:	STATE:	ZIP CODE:

PRIMARY CARE DOCTOR:		
ADDRESS:		PHONE:
CITY:	STATE:	ZIP CODE:

REFERRING DOCTOR:		
ADDRESS:		PHONE:
CITY:	STATE:	ZIP CODE:

**PLEASE REVIEW, SIGN AND DATE ON THE LINES BELOW

AUTHORIZATION FOR PAYMENT OF BENEFITS/RELEASE OF MEDICAL INFORMATION
I request that payments from my insurance company (companies) be made directly to ALLIED DERMATOLOGY AND SKIN SURGERY, LLC. I understand that I am responsible for any balances not covered by my insurance.
X SIGNATURE DATE
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
Signing below permits ALLIED DERMATOLOGY AND SKIN SURGERY, LLC to use and disclose health information about you for treatment, payment, and health care operations in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Copy available upon request)
X SIGNATURE DATE

*FOR OFFICE USE ONLY

INITIAL BELOW TO VERIFY ALL INFORMATION IS CORRECT

_____2024 _____2025 _____2026 _____2027 _____2028

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

MOHS Pre-Surgery Instructions:

- Please plan to bring a driver for your trip home. You can experience unexpected swelling that may impact your ability to drive, particularly if your cancer is on the face.
- 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 up to 4-6 hours the day of your procedure, although the actual time is likely to be less. 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 and we will be unavailable to you if 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.
- If possible please consider discontinuing vitamin supplements such as Vitamin E, Ginseng, Ginkgo, Garlic, Feverfew, Fish Oil, Echinacea and others that can contribute to bleeding and extra bruising for a week prior to your procedure.
- Take **ALL** prescribed medications as your normally would.
- **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 one week 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.
- **Depending on the cancer size and location, physical activities may be limited or restricted.**
- 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.

Visit our website for more information about the Mohs procedure including videos.

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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

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?
_____ _ How many
packs do you smoke a day? _____ Total years
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
- 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

PLEASE CIRCLE IF YOU HAVE HAD ANY SURGERIES ON 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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: (330) 665-0556
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Mayfield Heights, OH 44124

: (440) 266-5500
: (440) 266-5505
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Mentor, OH 44060

: (330) 871-9300
: (330) 665-0556
1560 Corporate Woods Pkwy
Uniontown, OH 44685

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PLEASE LIST YOUR MEDICATIONS BELOW:

PLEASE LIST ANY MEDICATION ALLERGIES YOU HAVE: