

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 (CIR	CLE ONE): HOME WORK	CELL				
IS IT OK TO LEAVE A DETAILED M	ESSAGE?* YES N	10				
*MESSAGES WOULD INCLUDE LAB WORK, BIOPSY RESULTS, ETC.						
EMAIL ADDRESS:						
MARITAL STATUS: S M	W					
*PRIMARY LANGUAGE: ENGLIS	SH SPANISH OTHER	DECLINE				
*RACE: CAUCASIAN AFRIC	CAN AMERICAN ASIAN [DECLINE				
*ETHNICITY: NON-HISPANIC	HISPANIC DECLINE					
*WE ARE REQUIRED TO COLLECT THIS DAT	A TO COMPLY WITH MEDICARE REQUIREMEN	ITS FOR ELECTRONIC MEDICAL RECORDS				
IN C	CASE OF EMERGENCY PLEASE CONT	ACT				
NAME:	RELATIONSHIP:	PHONE:				
DECDONCIDI E DADTY	(PRIMARY INSURANCE CARD HOL	DED) INFORMATION				
	T (PRIMART INSORANCE CARD HOL	DER) INFORMATION				
NAME:						
ADDRESS:						
CITY:	STATE:	ZIP CODE:				
SSN:	ATE OF BIRTH: SEX: M F					
PLEASE LIST ALL PERSONS PE	RMITTED TO SPEAK WITH REGARD	ING MEDICAL INFORMATION				
NAME:	RELATIONSHIP:	PHONE:				
NAME:	RELATIONSHIP:	PHONE:				

PATIENT REGISTRATION FORM

PATIENT NAME:			
	PHARMACY IN	FORMATION	
MAIL ORDER:			
LOCAL PHARMACY:		PHONE	:
ADDRESS:			
CITY:	STATE:		ZIP CODE:
PRIMARY CARE DOCTOR:		- 1	
ADDRESS:		PHONE	:
CITY:	STATE:	216-2 P	ZIP CODE:
REFERRING DOCTOR:			
ADDRESS:		PHONE	:
CITY:	STATE:	THE	ZIP CODE:
	FOR PAYMENT OF BENEF insurance company (companies) nsible for any balances not covere	be made directly to ALI	IEDICAL INFORMATION LIED DERMATOLOGY AND SKIN SURGERY,
X SIGNATURE	DATE		
AUTHORIZATION	FOR USE AND DISCLOSUI	RE OF PROTECTED	HEALTH INFORMATION
Signing below permits ALLIED DER treatment, payment, and health c (HIPAA) (Copy available upon requ	are operations in compliance wit	LLC to use and disclose I h the Health Insurance P	health information about you for ortability and Accountability Act of 1996
X SIGNATURE	DATE		
*FOR OFFICE USE ONLY INITIAL BELOW TO VER	RIFY ALL INFORMATION	IS CORRECT	
2024	2025 2	.026	2027 2028



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.

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



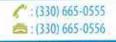
HAVE YOU HAD ANY OF THE FOLLOWING SKIN CONDITIONS?

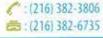
None -Acne -Actinic Keratosis -Basal Cell Skin Cancer -Blistering Sunburns -Dry Skin -Eczema

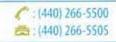
-Flaking or Itchy Scalp -Hay Fever/Allergies -Melanoma -Poison Ivy -Precancerous Moles - Psoriasis -Squamous cell skin cancer

PLEASE CIRCLE YOUR ANSWERS TO THE QU	ESTIONS
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 -Uncl	e
Aunt -Nephew -Niece	
Do you have a family history of Cancer? YES NO	
If yes, which relative? Mother -Father -Sister -Brother -Daughter -Son -Uncl -Aunt-Nephew -Niece What type of Cancer? Do you smoke? YES OR NO If yes, when did you sta	rt smoking? Quit?
packs do you smoke a day? you have been smoking?	_ How many Total years
Do you drink alcoholic beverages? YES OR NO If yes Less than 1 drink a week YES OR NO 1-2 drinks a day YES OR NO	s, how often?
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 YES OR NO	had Pneumonia Vaccine?
751 E. F. D.	

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PLEASE CIRCLE ANY OF THE FOLLOWING MEDICAL CONDITIONS THAT YOU CURRENTLY HAVE:

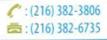
-None -Anxiety -Arthritis -Asthma -Atrial Fibrillation -Bone Marrow Transplantation -BPH - Breast Cancer - Colon Cancer -COPD -Coronary Artery Disease -Depression -Diabetes -End Stage Renal Disease -GERD -Hearing Loss -Hepatitis -Hypertension-HIV-AIDS -Hypercholesterolemia -Hypothyroidism -Leukemia -Lung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

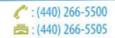
PLEASE CIRCLE IF YOU HAVE HAD ANY SURGERIES ON THE FOLLOWING ORGANS:

- 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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EASE LI	ST YOUR MEDICAT	TONS BELOW:	
LEASE LI	ST ANY MEDICATION	ON ALLERGIES YO	U HAVE:

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