



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? <input type="checkbox"/> Yes <input type="checkbox"/> No May we leave a message for you to return our call? <input type="checkbox"/> Yes <input type="checkbox"/> No
Home Phone: ( )	May we leave a detailed message regarding test results, appointments, and/or billing? <input type="checkbox"/> Yes <input type="checkbox"/> No May we leave a message for you to return our call? <input type="checkbox"/> Yes <input type="checkbox"/> No
Work Phone: ( )	May we leave a detailed message regarding test results, appointments, and/or billing? <input type="checkbox"/> Yes <input type="checkbox"/> No May we leave a message for you to return our call? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Circle your preferred contact method</b>	<b>Cell      Home      Work      Email</b>

\*\*\*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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any drug allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list any drugs you are allergic to:
--	---	---

### MEDICAL SYMPTOMS Please check all the apply

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

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

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

### Have you had any of the following conditions:

<input type="checkbox"/> Acne <input type="checkbox"/> Actinic Keratosis (pre skin cancer) <input type="checkbox"/> Basal Cell Skin Cancer <input type="checkbox"/> Blistering Sunburns <input type="checkbox"/> Dry Skin <input type="checkbox"/> Eczema	<input type="checkbox"/> Flaking or Itchy Scalp <input type="checkbox"/> Hay Fever/Allergies <input type="checkbox"/> Melanoma <input type="checkbox"/> Poison Ivy <input type="checkbox"/> Precancerous Moles <input type="checkbox"/> Psoriasis	<input type="checkbox"/> Squamous Cell Skin Cancer <input type="checkbox"/> Other _____ <input type="checkbox"/> None
--	--	---

Do you wear sunscreen? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what SPF?	Are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Previous history of pregnancies/births (list years)
--	---

Do you tan in a tanning salon? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a family history of melanoma? <input type="checkbox"/> Yes <input type="checkbox"/> 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**

<p>Tobacco Products Use?  <input type="checkbox"/> Current every day smoker  <input type="checkbox"/> Former every day smoker  <input type="checkbox"/> Never</p> <p>Date Started/Quit          _____</p> <p>Have you ever tested positive for TB?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Alcohol:  <input type="checkbox"/> None  <input type="checkbox"/> Less than 1 drink/day  <input type="checkbox"/> 1-2 drinks daily  <input type="checkbox"/> 3 or more drinks daily</p> <p>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          _____</p>	<p>Have you received your flu vaccination?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What year?          _____</p> <p>Have you received your pneumonia vaccination?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
--	---	--

**REVIEW OF SYSTEMS History or current problem with any of the following? (Please check all that apply)**

<p>Problems with bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Problems with healing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Problems with scarring (hypertrophic or keloid)  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Abdominal Pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anxiety <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bloody Stool <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bloody Urine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blurry Vision <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chest Pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cough <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Depression <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fever or Chills <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Grey Discoloration of Skin <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Immunosuppression <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Joint Aches <input type="checkbox"/> Yes <input type="checkbox"/> No          (if yes, indicate year _____)</p> <p>Menstrual Changes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Muscle Weakness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Neck Stiffness <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Night Sweats <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rash/Hives <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sleeplessness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sore Throat <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Unintentional Weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Vaginal Candidiasis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Wheezing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Red Eye <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tearing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Eye Pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Uncontrolled Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Elevated Blood Sugar <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Allergy to adhesive <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Allergy to Lidocaine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>-----          Allergy to topical antibiotic ointments  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Artificial heart valves <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Artificial joints in the last 2 yrs <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blood thinners <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Blood thinners <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Defibrillator <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>MRSA <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Currently Pregnant or planning a pregnancy  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Premedication prior to procedures  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rapid heartbeat with epinephrine  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ebola Risk: Fever &gt;+100.4 <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>West Africa: Travel or contact <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ebola Risk: contact w/ebola patient without          Proper protective equipment within the last          21 days <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ebola Risk: Headaches, weakness, muscle pain          Vomiting, diarrhea, abdominal pain, and/or          Hemorrhage <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Prostate Medications <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Transplant <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
---	--	---

Signature of Responsible Party/Date \_\_\_\_\_