

BRETT M. COLDIRON, M.D.
PATIENT REGISTRATION FORM

DATE

PATIENT INFORMATION					
PATIENT NAME (Last, First, MI)			REFERRING DOCTOR NAME		
ADDRESS (Street, Apt. No.)		EMPLOYER NAME		TELEPHONE (WORK) ()	
ZIP	CITY STATE		EMPLOYMENT ADDRESS		CITY/STATE/ZIP
TELEPHONE (Home) ()		PERSON TO CONTACT IN CASE OF EMERGENCY			TELEPHONE
DATE OF BIRTH	AGE	SEX	SOCIAL SECURITY NUMBER	SPOUSE NAME (Last, First)	TELEPHONE (WK)
RESPONSIBLE PARTY FOR BILLING IF DIFFERENT THAN PATIENT					
RESPONSIBLE PARTY NAME (Last, First, MI)		SOCIAL SECURITY NUMBER		PATIENT RELATIONSHIP TO RESPONSIBLE PARTY	
				<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD _____ OTHER	
RESPONSIBLE PARTY ADDRESS (Street, Suite No.)			EMP. OYER NAME		(Telephone)
CITY STATE ZIP			EMPLOYER ADDRESS		
TELEPHONE (Home)		TELEPHONE (OTHER)		CITY STATE ZIP	

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE REGARDLESS OF INSURANCE COVERAGE. WE DO NOT HONOR **DNR** (DO NOT RECESSITATE) OR LIVING WILL REQUESTS.

INSURANCE AUTHORIZATION AND ASSIGNMENT (PLEASE READ AND SIGN)

I HEREBY AUTHORIZE THE PHYSICIAN TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENT AND I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE, INCLUDING BUT NOT LIMITED TO AMBULATORY SURGICAL ROOM FEES. I AGREE TO PAY ALL BALANCE DUE IN FULL WITHIN TEN DAYS OF STATEMENT, UNLESS ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. I UNDERSTAND THAT A COPY OF THE OFFICE PRIVACY PRACTICES IS AVAILABLE UPON REQUEST AND IS POSTED ON WAITING ROOM BULLETIN BOARD.

DATE _____ SIGNATURE _____

Welcome to the Skin Cancer Center. Please fill out the following information so we can take better care of you. If you have trouble filling it out we will help you.

Your Name _____

1. Which doctor sent or referred you to us ? _____

Who is your regular dermatologist ? _____

2. What is your age ? _____

3. What is your occupation ? If retired, tell what you did before you retired.

4. Do you have skin cancer ? If no proceed to question # 9. YES NO

5. If yes, where, and for how long ? _____

6. If yes, has this been treated before(not counting the biopsy)? If yes how was it treated ?

(scraped and burned, frozen, x-rayed, cut out) _____

7. When was your skin cancer last biopsied ? _____

8. Was it a basal cell carcinoma or squamous cell carcinoma or other ?

Please list here _____

9. What is your past medical history ? For example do you have heart trouble?, diabetes? Artificial joints?

Artificial heart valve ?, high blood pressure ?, organ transplant ? _____

10. Do you have any drug/medication allergies ? If so list _____

11. What medicines are you currently taking ? _____

12. Do you take aspirin or arthritis medicine ? YES NO

13. Do you smoke ? YES NO If yes how many packs per day _____

14. Did you ever receive radiation treatment for acne ? _____

15. Have you read the booklet about Mohs surgery ? YES NO

16. Have you read the insert " About Dr. Coldiron " ? YES NO

17. Have you ever had any plastic surgery done ? YES NO

If yes what ? _____

18. Do you have a family history of skin cancer YES NO

Completed by: _____ Date _____

Reviewed By: _____ And _____

Brett M. Coldiron, M.D.