For clinic use only
MRN_____

DALLAS Skin Cancer Center

REGISTRATION

Today's date:	Referring Physician:	Primary Care Provider:

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:	Age:
Home Street Address:	City:	State:	Zip Code:
Phone Numbers: (please check primary contact number) ☐ Home: ☐ Mobile: ☐ Work:			Date of Birth:
Email Address:	Sex: ☐ Male ☐ Female	Ethnicity:	
S.S. #: (for insurance verification)	Preferred Language:	Occupation: If retired, former occupation?	

Preferred Method of Contact: ☐ Home phone ☐ Mobile phone ☐ Email ☐ Other:

May we leave a message regarding your protected health information through (CHECK ALL THAT APPLY):
☐ Voicemail ☐ Email ☐ Phone text ☐ Authorized person ☐ No, do not leave a message
Disclaimer: Our office sends phone call and text appointment reminders.

EMERGENCY CONTACT

Name:		Relationship to Patient:
Home Phone Number:	Mobile Phone Number:	Work Phone Number:

INSURANCE INFORMATION (please provide insurance card to receptionist) **Do you have insurance?** ☐ **Yes** ☐ **No**

Primary Insurance:		Precertification Phone Number:	
Subscriber's Name:		Subscriber's SS#:	Subscriber's DOB:
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	Group Number:	Policy / Member ID Number:	
Secondary Insurance: (if applicable)		Precertification Phone Number:	
Is Subscriber same as above? ☐ Yes ☐ No (explain)	Group Number:	Policy / Member ID Number:	

FINANCIAL POLICY

I hereby assign my insurance benefits to be paid directly to Dallas Skin Cancer Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment will be considered as valid as the original. I understand that all copays, deductibles, and payments for non-covered surgical procedures are due and payable at the time service is provided. I understand that I am financially responsible for all professional fees regardless of insurance coverage. I authorize Dallas Skin Cancer Center to release any information required to process my insurance claims. I have read, understand, and agree to this financial policy.

Patient Signature (or Legal Representative):	Date:

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Patient Name: _____Date:_____

MEDICAL HISTORY

MEDICAL CONDITIONS (Pease indicate if you have or had any of the following): ☐ None

- ☐ Artificial heart valve
- ☐ Artificial joints
- ☐ Vascular shunts
- ☐ Rheumatic heart disease
- ☐ Cardiac stents
- ☐ Heart defect
- ☐ Endocarditis
- ☐ Pacemaker / defibrillator
- ☐ Bleeding problems
- ☐ Keloids
- ☐ HIV / AIDS
- ☐ Hepatitis ☐A ☐B ☐C
- ☐ Organ transplant
  Type:_____Year:_____
- ☐ Staph infection
- ☐ GERD
- ☐ Lupus
- ☐ Atrial fibrillation
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Heart disease
- ☐ Lung disease
- ☐ Diabetes
- ☐ Any other cancers:
  Type:_____Year:_____
  Treatment:_____
- ☐ Stroke / TIA
- ☐ High blood pressure
- ☐ Arthritis
- ☐ Previous skin cancer
- ☐ Mohs surgery
- ☐ Radiation treatment
- ☐ Problems healing
  Explain:_____
- ☐ Seizures

FAMILY HISTORY (include only first degree relatives - mother, father, siblings, children) ☐ None

- ☐ Lupus
- ☐ Rheumatoid arthritis
- ☐ Multiple sclerosis
- ☐ Leukemia
- ☐ Lymphoma

Please specify which relative(s):

MEDICATIONS (please indicate if you take the following medications): ☐ None

- ☐ Aspirin
- ☐ Plavix/ clopidogrel
- ☐ Coumadin / warfarin
- ☐ Pradaxa / dabigatran
- ☐ Xarelto / rivaroxaban
- ☐ Aggrenox
- ☐ Brilinta / ticagrelor
- ☐ Eliquis / apixaban
- ☐ Other blood thinners
- ☐ Herbal supplements
- ☐ Vitamin E
- ☐ Steroids / Prednisone
- ☐ Fish or Flaxseed oil

Please list all other medications (prescribed and over-the-counter). Attach separate sheet if needed:

_____

_____

_____

_____

Medication allergies and type of reaction: ☐ None ☐ Latex allergy

Does your dentist prescribe antibiotics before dental procedures? ☐ No ☐ Yes

SOCIAL HISTORY

Do you currently smoke or use tobacco? ☐ No ☐ Yes: _____# packs per day ☐ Former use (explain)

Do you drink alcohol? ☐ No ☐ Yes: _____# drinks per week or _____# drinks per day

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Patient Name: _____Date:_____

SOCIAL HISTORY (continued)	
History of tanning bed use? ☐No ☐Yes (explain)	
History of blistering sunburns in childhood? ☐No ☐Yes (explain)	
History of problems with your skin other than skin cancer? ☐No ☐Yes (explain)	
How far away do you live?	
Is there someone at home to help with wound care? ☐ No ☐ Yes	
PHARMACY INFORMATION	
Pharmacy Name:	Phone Number:
Pharmacy Address:	

Is there anything else you want your doctor to know that may affect treatment, surgery, or recovery?

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