DSWO DERMATOLOGISTS OF SOUTHWEST OHIO, INC.

DGC DERMATOLOGISTS OF GREATER COLUMBUS
Dublin • Grove City • Upper Arlington
Washington Court House
Board Certified Dermatologists

TWIN OAKS DERMATOLOGY

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:	Primary Language	
Marital Status : **Single** **Married** **Divorced** **Widowed**			
Social Security Number:	Spouse Name (if applicable)	Caretaker Name (if applicable)	

Medical Information Release
(Dermatologists of Greater Columbus Privacy Policies are located at the reception desk)

Cell Phone: ( )	May we leave a detailed message regarding test results, appointments, and/or billing? ❑ Yes ❑ No May we leave a message for you to return our call? ❑ Yes ❑ No
Home Phone: ( )	May we leave a detailed message regarding test results, appointments, and/or billing? ❑ Yes ❑ No May we leave a message for you to return our call? ❑ Yes ❑ No
Work Phone: ( )	May we leave a detailed message regarding test results, appointments, and/or billing? ❑ Yes ❑ No May we leave a message for you to return our call? ❑ Yes ❑ No
Circle your preferred contact method	**Cell** **Home** **Work** **Email**

***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 _____

Employer/Place of Employment:

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 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 Greater Columbus

Thank you for choosing Dermatologists of Greater Columbus. The following in 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.

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.

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 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.

Available forms of payment include: cash, check, MasterCard, and Visa.

Cosmetic Procedures: Payment is expected in full at the time of your procedure.

Lab Fee: Dermatologists of Greater Columbus and Dermatologists of Southwest Ohio use an outside laboratory for pathology services. When possible the practice will bill for the laboratory services.

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. Prompt payments is expected.

Initial _____

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.

My Signature below indicated that I have read and agree to the above written financial policy of Dermatologists of Greater Columbus.

_____ _____

Signature of Responsible Party **Date**

PATIENT INFORMATION

Name:	Date of Birth:	Account #:

Latex allergy?	Any drug allergies?	If yes, list any drugs you are allergic to:
❑ Yes ❑ No	❑ Yes ❑ No	

MEDICAL SYMPTOMS
Please check all the apply

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

Have you had an surgeries in the following organs
Please check all the apply

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

Have you had any of the following conditions:

❑ Acne	❑ Melanoma
❑ Actinic Keratosis (pre skin cancer)	❑ Poison Ivy
❑ Basal Cell Skin Cancer	❑ Precancerous Moles
❑ Blistering Sunburns	❑ Psoriasis
❑ Dry Skin	❑ Squamous Cell Skin Cancer
❑ Eczema	❑ Other _____
❑ Flaking or Itch Scalp	❑ None
❑ Hay Fever/Allergies	

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 ❑ Grandmother
❑ Grandfather ❑ Grandson ❑ Granddaughter ❑ Other _____ ❑ None

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

Alcohol:
❑None
❑ Less than 1 drink/day
❑ 1-2 drinks daily
❑ 3 or more drinks daily

Have you ever felt you should cut down on your drinking? ❑ Yes ❑ No
Have people annoyed you by criticizing your drinking? ❑ Yes ❑ No
Have you ever felt bad or guilty about your drinking? ❑ Yes ❑ No
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? ❑ Yes ❑ No

Tobacco Products Use?
❑ Current every day smoker
❑ Former every day smoker
❑ Never

Have you ever tested positive for TB? ❑ Yes ❑ No

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

Problems with bleeding ❑ Yes ❑ No	Hay Fever ❑ Yes ❑ No	Allergy to adhesive ❑ Yes ❑ No
Problems with healing ❑ Yes ❑ No	Headaches ❑ Yes ❑ No	Allergy to Lidocaine ❑ Yes ❑ No
Problems with scarring (hypertrophic or keloid) ❑ Yes ❑ No	Immunosuppression ❑ Yes ❑ No	Allergy to topical antiobiotic ointments ❑ Yes ❑ No
Abdominal Pain ❑ Yes ❑ No	Joint Aches ❑ Yes ❑ No	Artificial heart valves ❑ Yes ❑ No
Anxiety ❑ Yes ❑ No	Muscle Weakness ❑ Yes ❑ No	Artificial joints in the last 2 yrs ❑ Yes ❑ No
Bloody Stool ❑ Yes ❑ No	Neck Stiffness ❑ Yes ❑ No	Blood thinners ❑ Yes ❑ No
Bloody Urine ❑ Yes ❑ No	Night Sweats ❑ Yes ❑ No	Defibrillator ❑ Yes ❑ No
Blurry Vision ❑ Yes ❑ No	Rash/Hives ❑ Yes ❑ No	MRSA ❑ Yes ❑ No
Congestive Heart Failure ❑ Yes ❑ No	Seizures ❑ Yes ❑ No	Pacemaker ❑ Yes ❑ No
Cough ❑ Yes ❑ No	Shortness of Breath ❑ Yes ❑ No	Pregnancy or planning a pregnancy ❑ Yes ❑ No
Depression ❑ Yes ❑ No	Sleeplessness ❑ Yes ❑ No	Premedication prior to procedures ❑ Yes ❑ No
Dizziness ❑ Yes ❑ No	Sore Throat ❑ Yes ❑ No	Rapid heartbeat with epinephrine ❑ Yes ❑ No
Fever or Chills ❑ Yes ❑ No	Thyroid Problems ❑ Yes ❑ No	
Grey Discoloration of Skin ❑ Yes ❑ No	Unintentional Weightloss ❑ Yes ❑ No	
	Vaginal Candidiasis ❑ Yes ❑ No	
	Wheezing ❑ Yes ❑ No	

Patient Signature _____ date _____