SKIN SURGERY CENTER of OKLAHOMA
MOHS SURGERY AND DERMATOLOGIC SURGERY

MEDICAL HISTORY AND INTAKE FORM

Patient Name: ______________________________ **Date of Birth:** (MM/DD/YYYY): ______________

RACE	ETHNIC GROUP	PREFERRED LANGUAGE
❍ American Indian or Alaskan Native	❍ Hispanic	❍ English
❍ Asian	❍ Latino	❍ Other______________
❍ Black/African American	❍ Not Hispanic or Latino	❍ Decline to specify
❍ Native Hawaiian or Other Pacific Islander	❍ Unknown	
❍ White	❍ Decline to specify	
❍ Other Race______________		
❍ Decline to specify		

Where were you born? (State and Country): ______________________________

Who is your Primary Care Physician? (Name and Phone Number):

____

What is the name of the Physician who referred you to our clinic? (Name and Phone Number):

____

Our Providers participate in E-Prescribing. Please provide the following information:

Pharmacy Name: ______________________________ **Phone Number:** ______________

Pharmacy Address: ______________________________

____

PAST MEDICAL HISTORY: (CHECK ALL THAT APPLY. IF NONE, PLEASE CHECK NONE)			
❍ None	❍ COPD	❍ End Stage Renal Disease	❍ Radiation Treatment
❍ Atrial Fibrillation	❍ Coronary Artery Disease	❍ Leukemia	
❍ CVA-Stroke	❍ Diabetes	❍ Lymphoma	

PAST SURGICAL HISTORY: (CHECK ALL THAT APPLY. IF NONE, PLEASE CHECK NONE)		
❍ None	❍ Knee Joint Replacement (Right, Left, Bilateral)	❍ Mechanical Heart Valve Replacement
❍ Basal Cell Cancer Surgery	❍ Hip Joint Replacement (Right, Left, Bilateral)	❍ Pacemaker
❍ Melanoma Surgery	❍ PTCA (angioplasty, heart stent)	❍ Heart Transplant
❍ Squamous Cell Cancer Surgery	❍ Biological Heart Valve Replacement	❍ Other______________________

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Patient Name: ______________________________

SKIN DISEASE HISTORY: (CHECK ALL THAT APPLY. IF NONE, PLEASE CHECK NONE)

❍ None	❍ Dysplastic nevus of skin (precancerous moles)	❍ Squamous Cell Skin Cancer
❍ Actinic Keratosis (AK's)	❍ Melanoma	❍ Other__________
❍ Basal Cell Skin Cancer	❍ Psoriasis	

Do you wear Sunscreen? ❍ Yes ❍ No If Yes, what SPF?_____ Do you tan in a tanning salon? ❍ Yes ❍ No

Family History of Melanoma? ❍ Yes ❍ No

If yes, whom: ______________________________

MEDICATIONS: (ALL CURRENT MEDICATIONS INCLUDING NON-PRESCRIPTION AND BIRTH CONTROL; IF NONE, MARK N/A)

____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

ALLERGIES (NON-SEASONAL): (PLEASE LIST ANY ALLERGIES THAT YOU HAVE, AND THE REACTION YOU HAD. IF NONE, MARK N/A)

SOCIAL HISTORY:

❍ Non-Smoker ❍ Former Smoker ❍ Current Smoker

Alcohol: ❍ None ❍ 1 or less per day ❍ 1-2 per day ❍ 3 or more per day IV Drug Use:______________

IMMUNIZATIONS:

Influenza ❍ Yes ❍ No Recommended by primary care but refused? If yes, date______________

Pneumonia ❍ Yes ❍ No Recommended by primary care but refused? If yes, date______________

REVIEW OF SYSTEM:

SYMPTOM	YES	NO	SYMPTOM	YES	NO
Swollen Lymph Nodes			Do you have a Pacemaker?		
Pregnant or current trying to become pregnant			Do you have an Artificial Heart Valve?		
Changing Moles; Other than primary reason for visit			Have you had Artificial Joint Surgery in the past 2 years?		
Problem with Healing			History of Rapid Heart Beat with Epinephrine?		
Chest Pain			Are you taking Blood Thinning Medication?		
Shortness of Breath			Do you have a history of Bleeding Problems?		
Cough			Do you require Antibiotics prior to procedures?		
Unintentional Weight Loss			History of Allergy to Band Aids or Adhesive Tape?		
Fever or Chills			History of Keloid or Hypertrophic Scarring?		
Headaches			History of MRSA (Resistant Staph Infections)?		
Anxiety			Do you have HIV/AIDS?		
Do you have a Defibrillator?			Do you have a history of Hepatitis B or C?		

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PATIENT INFORMATION

PATIENT'S LEGAL NAME:

First: Middle: Last: Gender:

DATE OF BIRTH: **SOCIAL SECURITY NUMBER:** **MARITAL STATUS:**

MAILING ADDRESS: Street City State Zip

Email Address: **Employer:** **Job Title:**

Home Phone: **Cell Phone:** **Work Phone:** *(please circle primary contact number)*

May we leave a message on voicemail/answering machine for appointments, test results, and instructions? ❍ Yes ❍ No

Phone number we should leave a message at:

Person to Notify in the Event of Emergency: ____________ ____________ ____________

Name Relationship Phone Number

INSURANCE PARTY INFORMATION ***COPAYMENTS AND DEDUCTIBLES ARE EXPECTED AT TIME OF SERVICE

Primary Insurance	Policy Holder's Name	Policy Holder DOB/Relationship to Patient
Secondary Insurance	Policy Holder's Name	Policy Holder DOB/Relationship to Patient

RELEASE OF MEDICAL RECORDS INFORMATION

I authorize SSCO to release information with regard to my care and treatment to the following *individuals/family members*:

Name	Relationship	Phone Number
Name	Relationship	Phone Number

LEGAL INFORMATION

Assignment of Benefits: The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Skin Surgery Center of Oklahoma and its related companies. I understand that I am financially responsible for any balance. I also authorize Skin Surgery Center of Oklahoma and its related companies, or insurance company to release medical information required to process claims.

Notice of Privacy Practices: I have read or been offered a copy of Skin Surgery Center of Oklahoma Notice of Privacy Practices (NPP), which explains how my medical information will be used and disclosed. I authorize the release of my medical information necessary to provide care and bill on my behalf. I understand I am entitled to a copy of the NPP. I authorize pictures of myself and of clinical focus areas to be stored in my medical record.

Consent for Communication: I understand Skin Surgery Center of Oklahoma will send appointment reminders and information on services via telephone, text message, and/or email based on contact information I provided. I understand that I will have the option to opt out of future text/email reminders.

Payment Policy: Payment is due at time of service including copays, deductibles, non-covered and cosmetic procedures, and prior balance due. I understand I am responsible for all charges for services rendered on my behalf, or on behalf of my dependents, less any amount paid by insurance to Skin Surgery Center of Oklahoma and its related companies.

Legal: This form applies to Skin Surgery Center of Oklahoma and its related companies.

Patient/Guardian Signature: Date: