Personalized, expert skin care.

Kailua Kona: (808) 329-1146
Waimea: (808) 885-3376
DrMonicaScheel.com

PATIENT REGISTRATION FORM

IMPORTANT! Please fill out this form and return it to our office one week before your appointment.

Legal First Name			Legal Last Name	Preferred Name
Date of Birth	Age	Sex ❑ Male ❑ Female	Email Address	

Mailing Address	City	State	Zip Code

Home Phone	Work Phone	Mobile Phone
Parent of Guardian (if patient is a minor)		Today's Date

Preferred Method of Contact: ❑ Home Phone ❑ Mobile Phone ❑ Email ❑ It's OK to leave a message regarding appointments or results

Primary Insurance Company	Subscriber #
Secondary Insurance Company	Subscriber #

Primary Care Provider		
Preferred Pharmacy	Location	Phone
Emergency Contact	Relationship	Phone

How did you hear about us? (check all that apply) ❑ NONE

❑ Friend* ________________________ ❑ Physician ________________________ ❑ Television ______________________

❑ Magazine _______________________ ❑ Radio __________________________ ❑ Website ________________________

❑ Newspaper ______________________ ❑ Social Media _____________________ ❑ Other __________________________

*Give us the name of your referring friend and they will receive a $50 gift certificate as a thank you.

Medical History

Past Medical History (check all that apply): ❑ NONE

- ❑ Anxiety
- ❑ Arthritis
- ❑ Atrial Fibrillation
- ❑ Bone Marrow Transplant
- ❑ Breast Cancer
- ❑ Cold Sores
- ❑ Colon Cancer
- ❑ COPD
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes
- ❑ GERD
- ❑ Hearing Loss
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ High Blood Pressure
- ❑ HIV/AIDS
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Leukemia
- ❑ Lung Cancer
- ❑ Lymphoma
- ❑ Prostate Cancer
- ❑ Radiation Treatment
- ❑ Seizures
- ❑ Stroke
- ❑ Substance Abuse
- ❑ Hyperthyroidism
- ❑ Hypothyroidism

Other: ______________________________

Past Surgical History (check all that apply): ❑ NONE

- ❑ Colectomy
- ❑ Coronary Artery Bypass
- ❑ Heart Valve Replacement
- ❑ Heart Transplant
- ❑ Joint Replacement specify joint: __________
- ❑ Kidney Biopsy
- ❑ Kidney Stone Removal
- ❑ Kidney Removed ❑ Left ❑ Right
- ❑ Kidney Transplant
- ❑ Ovaries Removed
- ❑ Prostate Surgery
- ❑ Testicles Removed
- ❑ Hysterectomy

Other: ______________________________

Skin Disease History (check all that apply): ❑ NONE

- ❑ Acne
- ❑ Asthma
- ❑ Blistering Sunburns
- ❑ Dry Skin
- ❑ Eczema
- ❑ Flaking or Itchy Scalp
- ❑ Hay Fever/Allergies
- ❑ Poison Ivy
- ❑ Precancerous Moles
- ❑ Psoriasis

Other: ______________________________

Skin Cancer History (check all that apply): ❑ NONE

- ❑ Basal Cell Carcinoma — Location/Year/Treatment: ______________________________
- ❑ Squamous Cell Carcinoma — Location/Year/Treatment: ______________________________
- ❑ Melanoma — Location/Year/Treatment: ______________________________
- ❑ Actinic Keratosis (Pre-Cancers) — Location/Year/Treatment: ______________________________
- ❑ Dysplastic Nevus (Pre-Cancers) — Location/Year/Treatment: ______________________________

Family Skin Cancer History (check all that apply): ❑ NONE

- ❑ Basal Cell Carcinoma — Family Member: ______________________________
- ❑ Squamous Cell Carcinoma — Family Member: ______________________________
- ❑ Melanoma — Family Member: ______________________________
- ❑ Actinic Keratosis (Pre-Cancers) — Family Member: ______________________________

Cosmetic Treatment History (check all that apply): ❑ NONE

- ❑ Fillers — When/Where: ______________________________
- ❑ Relaxers (Botox/Dysport) — When/Where: ______________________________
- ❑ Laser Treatment — When/Where: ______________________________
- ❑ Cosmetic Surgery — When/Where: ______________________________

Any other cosmetic concerns? ______________________________

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____

Do you wear sunscreen? ❑ Yes ❑ No What SPF? _________ Do you apply sunscreen daily? ❑ Yes ❑ No

Medications (list all current): ❑ NONE

____

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____

Supplements (list all current): ❑ NONE

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____

____

Allergies (list all): ❑ NONE

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____

Patient Health

Do you smoke? ❑ Yes ❑ No

Alcohol use: ❑ None ❑ Less than 1 drink per day ❑ 1-2 drinks per day ❑ 3+ drinks per day

Please describe your eating philosophy: ____

____

Outdoor activities? ____

____

How many serving a day of: Vegetables ____________ Fruit ____________ Glasses of water ____________

Your occupation & workplace: ____

Other Important History (check all that apply): ❑ NONE

- ❑ Allergy to Adhesives
- ❑ Allergy to Lidocaine
- ❑ Allergy to Shellfish
- ❑ Allergy to Topical Antibiotics
- ❑ Artificial Heart Valve
- ❑ Artificial Joint Replacement
- ❑ Take Blood Thinners
- ❑ Have a Defibrillator
- ❑ Have a Pacemaker
- ❑ Require Antibiotics Prior to a Surgical Procedure
- ❑ Rapid Heartbeat with Epinephrine
- ❑ Are you pregnant or currently trying to get pregnant?
- ❑ Are you breastfeeding?

What is your concern today? ____

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Financial Policy

***Dr. Scheel is not a provider for any insurance plans. We encourage you to contact your insurance company regarding reimbursement. If you have an HMO, you will need to contact your PCP before your appointment and be approved through an Administrative Review process.* If you are eligible for Medicare, you will be required to sign our Medicare opt-out form as Medicare doesn't reimburse for visits to our office.**

Payment: Payment is required at the time of service. We accept most major credit cards as well as cash, checks, and care credit. Please note that there is a $25 fee for any returned checks. We will be happy to provide you with a receipt you can submit to your insurance company for reimbursement (insurance companies may reimburse some of your visit to a non-network doctor).

Cancellations: If you miss or cancel an appointment with less than 24-hour notice, you will be billed a $50 cancellation fee.

Confirmation: We make every effort to remind you of your upcoming appointments and confirm your appointment times. If after three attempts to confirm your appointment with no response, we reserve the right to fill your appointment time. You will then be responsible for rescheduling your appointment.

Here at Dr. Monica Scheel Dermatology, we strive to maintain an environment that is caring, friendly, professional, and safe. We appreciate that all patients and staff are treated with courtesy and respect. We will not tolerate threatening, violent, disrespectful or otherwise inappropriate behavior. Such interaction will result in dismissal from the practice as a patient.

By supplying my phone numbers, email address, and any other personal contact information, I authorize Dr. Monica Scheel Dermatology to employ a third-party automated outreach and messaging system to use my personal information, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, or any other healthcare related function. I also authorize Dr. Monica Scheel Dermatology to disclose to third parties, which may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from Dr. Monica Scheel Dermatology, when necessary. I consent to allow detailed messages being left on my voice mail, answering system, or with another individual if I am unavailable at the number provided by me.

Your signature below indicates you understand and accept this policy, and that you have received our patient privacy policy.

____ ____________________
Signature of Patient or Legal Guardian **Date**

____
Print Legal Name

FAX: (808) 329-1120 frontoffice@drmonicascheel.com