DR MONICA SCHEEL
DERMATOLOGY
Expert and Personalized Skin Care

Refresh BY DR. MONICA

Personalized, expert skin care.
Kailua Kona: (808) 329-1146
Waimea: (808) 885-3376
Drmonicascheel.com

Patient Registration Form

IMPORTANT! Please fill out this form prior to 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
Guardian Name (if patient is a minor)					Today's Date

Preferred Method of Contact: ❑ Home Phone ❑ Mobile Phone ❑ Email

❑ It's OK to leave a detailed message regarding appointments or results

❑ It's OK to send a detailed text message regarding appointments or results

❑ Please Do Not Leave Detailed Messages or Results

Emergency Contact	Relationship	Phone
May we speak to this person about your health? ❑ Yes ❑ No		
Can we speak to or release your health information to anyone else? If yes, please list below		
Name	Relationship	Phone
Primary Care Provider		
Preferred Pharmacy	Location	Phone

We do not participate with insurance but need a copy for the pharmacy, labs, and pathology

Primary Insurance Company Subscriber #
Subscriber Name and Relationship Subscriber Birthdate

How did you hear about us? *Write the name of the friend that referred you and they will receive a $50 referral as thank you.

❑ Friend* _____	❑ Physician	❑ Television	❑Magazine
❑ Radio	❑ Website	❑ Newspaper	❑ Social Media

Reason for visit today:_____

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

Medical History

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

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

❑ Colectomy	❑ Hysterectomy	❑ Kidney Stone Removal	❑ Testicle Removal
❑ Coronary Artery Bypass	❑ Joint Replacement	❑ Kidney Transplant	❑ Other
❑ Heart Transplant	❑ Kidney Biopsy	❑ Prostate Surgery	❑ Other
❑ Heart Valve Replacement	❑ Kidney Removal	❑ Removal of Ovaries	❑ Other

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

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

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

❑ Actinic Keratosis (Precancers)	❑ Dysplastic Nevus (Precancerous moles)	❑ Squamous Cell Carcinoma
❑ Basal Cell Carcinoma	❑ Melanoma	❑ Other

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

❑ Actinic Keratosis (Precancers)	Family Member:
❑ Basal Cell Carcinoma	Family Member:
❑ Dysplastic Nevus (Precancerous moles)	Family Member:
❑ Melanoma	Family Member:
❑ Squamous Cell Carcinoma	Family Member:

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

❑ Filler	Area:	When:
❑ Relaxers (Botox/Dysport/Xeomin)	Area:	When:
❑ Laser Treatment	Area:	When:
❑ Cosmetic Surgery	Area:	When:
❑ Other	Area:	When:

Do you have any cosmetic concerns today?_____

Medications & Supplements (list all current): ❑ NONE

_____
_____
_____
_____
_____
_____

Allergies (list all): ❑ NONE

_____
_____
_____
_____
_____

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

❑ Allergy to Adhesives	❑ Allergy to topical antibiotics	❑ Have a defibrillator	❑ Require antibiotics prior to surgical procedures
❑ Allergy to bee stings	❑ Artificial heart valve	❑ Has a pacemaker	❑ Taking blood thinners
❑ Allergy to lidocaine	❑ Artificial Joint Replacement	❑ Pregnant or currently trying to get pregnant	❑ Other
❑ Allergy to shellfish	❑ Breastfeeding	❑ Rapid heart beat with epinephrine	❑ Other

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

Your occupation & workplace:_____

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. 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). Please note that there is a $25 fee for any returned checks.

Cancellation Notice and Fees:

- **Cancellations within 24 Hours for Appointments Tuesday to Friday:**
    - You must cancel 24 hours in advance to avoid being charged a late fee of $50. If you cancel within 24 hours you will be charged a $50 late cancellation fee.
- **Cancellations within 24 Hours for Monday Appointments:**
    - You must cancel by Friday at 12:00PM to avoid being charged a late fee of $50. If you cancel after 12:00PM on Friday you will be charged a $50 late cancellation fee.

No-Show/ Late Cancellation Fees:

- If you do not show up for your scheduled appointment and did not provide any notice, the fees are as follows:
    - First no-show: $50
    - Second no-show: $75
    - Third no-show: $100
    - Each subsequent no-show will incur an additional $25 increase.

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 receiving multiple messages per day from Dr. Monica Scheel Dermatology, when necessary. I consent to allow detailed messages being left on my voicemail, 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