Twin Oaks
DERMATOLOGY & EYE SURGERY
a DOCS affiliate

REGISTRATION FORM

PATIENT INFORMATION

Last Name: ______________________________ **First Name:** ___________________________________

Preferred Name: _________________________ **Date of Birth:** ________________ **Gender at Birth:** ☐ Male ☐ Female

Which pronouns do you use? ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Other __________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Mobile Phone #: __________________________________ **Other (work/home) #:** ________________________

Home Address: ___________________________________ **City, State, Zip:** _______________________________

Do you have an Ohio Living Will: ☐ Yes ☐ No **Health Care Power of Attorney:** ____________________________________

Please sign up for our patient portal today. Our portal gives you access to your health care data and most importantly you can communicate with us through the secure portal system. You can ask questions or refill your medications through the portal. Please be advised that it may take up to 3 working days to answer your request.

Patient's Email: ____

Primary Care Provider: _______________________ **Location:** _________________________ **Phone:** _____________________

Preferred Pharmacy: _________________________ **City:** ______________________________ **State:** ______________________

MINOR

Is Patient Under 18? ☐ Yes *(If yes, please complete below financial guarantor information)* ☐ No

Guarantor Full Name: _____________________________________ **Date of Birth:** ____/____/____

Guarantor Address: _______________________________________ **City, State, Zip:** ______________________________

Relation to Patient: ☐ Parent ☐ Spouse ☐ Other: _______________________________________

REVIEW OF SYSTEMS

History or current problem with any of the following? (Please check all that apply)

☐None	☐ Problems with bleeding	☐ Problems with healing
☐Problems with scarring	☐ Abdominal Pain	☐ Anxiety
☐ Bloody Stool	☐ Bloody Urine	☐ Blurry Vision
☐ Chest Pain	☐ Cough	☐ Depression
☐ Dizziness	☐ Fever or Chills	☐ Hay Fever
☐ Headaches	☐ Immunosuppression	☐ Joint Aches
☐ Menstrual Changes	☐ Muscle Weakness	☐ Neck Stiffness
☐Night Sweats	☐ Rash/Hives	☐ Seizures

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REVIEW OF SYSTEMS CONT.

☐ Shortness of Breath ☐ Sleeplessness ☐ Sore Throat
☐ Thyroid Problems ☐ Unintentional Weight Loss ☐ Vaginal Candidiasis
☐ Wheezing ☐ Red Eye ☐ Tearing
☐ Eye Pain ☐ Uncontrolled Blood Pressure ☐ Elevated Blood Sugar
☐ Other________________

ALERTS

Do you have any of the following:

☐ None ☐ Allergy to Adhesive ☐ Allergy to Lidocaine
☐ Allergy to topical Antibiotic Ointments ☐ Artificial Heart Valves ☐ Artificial Joints in the 2 years
☐ Blood Thinners ☐ Defibrillator ☐ Pacemaker
☐ Pregnancy/Planning a Pregnancy ☐ Premedication Prior to Procedures
☐ Rapid Heartbeat with Epinephrine ☐ Prostate Medications ☐ Transplant Patient
☐HIV ☐ History of MRSA ☐ History of Melanoma
☐ History of Non-Melanoma Skin Cancer ☐ History of Dysplastic Nevi ☐ History of Hepatitis
☐ History of Merkel Cell Carcinoma ☐ History of Atypical Junctional Melanocytic Hyperplasia

MEDICATIONS

Medication Name	Dosage	Frequency	Route

MEDICAL PROBLEMS

Please list any medical problems. Otherwise write None:
____
____
____

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SURGERIES

Please list any surgies you've had. Otherwise write None:

____

____

ALLERGIES

Please list any drugs you are allergic to. Otherwise write None:

____

____

____

BLOOD THINNERS

Please list any blood thinners you are on. Otherwise write None:

____

____

____

SKIN DISEASE HISTORY

Have you had any of the following?

☐ None ☐ Acne ☐ Actinic Keratoses (Pre-Skin Cancers)

☐ Asthma ☐ Basal Cell Skin Cancer ☐ Blistering Sunburns

☐Dry Skin ☐ Eczema ☐ Flaking or Itchy Scalp

☐ Hay Fever / Allergies ☐ Poison Ivy

☐ Precancerous Moles ☐ Psoriasis

☐ Squamous Cell Skin Cancer ☐ Melanoma

☐ Other_______________

Do you have a family history of Melanoma?

☐ Yes ☐ No

If yes, which relative? ________________

Do you wear sunscreen? ☐ Yes ☐ No

If yes, what is the SPF? __________________

Do you tan in a tanning salon? ☐ Yes ☐ No

SOCIAL HISTORY

Do you currently smoke? ☐ Yes ☐ No

Are you a former smoker? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

How many drinks per day? ☐ <1 ☐ 1-2 ☐ 3+

VACCINATIONS

Have you received your pneumonia vaccination? ☐ Yes ☐ No

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