

# Patient Registration Form

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Title: Mr. \_\_\_ Ms. \_\_\_ Mrs. \_\_\_ Dr. \_\_\_

Name: \_\_\_\_\_ but please call me: \_\_\_\_\_

Date of birth: \_\_\_\_\_ (Age: \_\_\_\_\_)

If child, name of parents or guardian: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Email address: \_\_\_\_\_

I prefer to be contacted at: Home \_\_\_ Work \_\_\_ Cell \_\_\_ Email \_\_\_

It is OK to leave a message on my phone regarding appointments \_\_\_ results \_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary Insurance Name: \_\_\_\_\_ Policy # \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_ Policy# \_\_\_\_\_

In case of emergency contact: \_\_\_\_\_ # \_\_\_\_\_ relationship \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Location \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about us (newspaper, phone book, web, if a friend please name) \_\_\_\_\_

## IMPORTANT!

Please fill out this form and mail/fax to our office **1 week before your appointment**. These forms are reviewed prior to your visit to insure a more comprehensive and thorough visit with Dr. Scheel.

## Sun Exposure and Skin Cancer History:

Average # of hours outside per week: \_\_\_\_\_

Outdoor activities: (circle) Walking Running Gardening Working outside Cycling  
Swimming Surfing Boating Fishing Hiking Snorkeling Diving Tennis Beach  
Golf Paddling Kayaking Motorcycle Convertible Others: \_\_\_\_\_

How long have you lived in Hawaii? \_\_\_\_\_

While growing up was your sun exposure: Minimal? \_\_\_ Moderate? \_\_\_ Intense? \_\_\_

Family history of skin cancer? (Who? Kind?) \_\_\_\_\_

Last dermatology visit? \_\_\_\_\_ Dermatologist: \_\_\_\_\_

History of skin cancer? \_\_\_\_\_ Basal cell / Squamous cell/ Melanoma

Location (year): \_\_\_\_\_ Treatment Done: liq. nitrogen/Efudex

History of precancers? \_\_\_\_\_ Floroplex/Carac/Aldara/Photodynamic  
Therapy/Surgical Excision/Moh's

## Current Skin Care:

What do you use for sun protection (please circle)? sunscreen SPF \_\_\_\_\_ / Brand \_\_\_\_\_  
ball cap / brimmed hat / rash guard / long sleeve shirts / pants / sunguard laundry  
powder / sun protective clothing

Do you? avoid mid day sun / apply sunscreen 20min before exposure / reapply every  
2hrs if out continuously / use sunscreen daily

What products are you using on your skin?

Face /body wash: \_\_\_\_\_

Moisturizer (face, body): \_\_\_\_\_ SPF of \_\_\_\_\_

Anti-aging products: \_\_\_\_\_

Brands of makeup: \_\_\_\_\_ SPF of \_\_\_\_\_

Exfoliators/masks/other: \_\_\_\_\_

Deodorant: \_\_\_\_\_

Have you had (circle)? a facial / microdermabrasion / chemical peels / photofacial(IPL)  
laser surgery / facelift / Botox/ fillers/ photodynamic therapy/ other cosmetic surgery

## Past Medical History:

Medical Problems (circle): high blood pressure / diabetes / high cholesterol / thyroid d/o sinus allergies / asthma / herpes / HIV / depression / anxiety / substance abuse / hepatitis kidney problems/ liver problems/ heart problems/ cancer...type \_\_\_\_\_

Surgeries: \_\_\_\_\_

Medications/doses: \_\_\_\_\_

Family history of breast cancer? YES NO If yes, who: \_\_\_\_\_

Drink alcohol? Y/N # drinks/week \_\_\_\_\_ Smoke? Y/N #Pack/day \_\_\_\_\_ Drugs? Y/N

Do you take blood thinners? Aspirin Ibuprofen(Motrin) Vitamin E Warfarin Plavix Other

Do you have a pacemaker? Yes No Do you have an artificial joint? Yes No

Medication allergies? Yes No If yes, please list: \_\_\_\_\_

## Diet and Nutrition:

Please describe your eating philosophy: \_\_\_\_\_

Do you (please circle)? eat **organic** foods / shop at the **health food store** / shop at the **farmer's market** / eat mainly **unprocessed foods** / I am **Vegetarian**/ I am **Vegan**

Please indicate # of times a week you eat: Cheese \_\_\_\_\_ Butter \_\_\_\_\_ Olive Oil \_\_\_\_\_

Fish \_\_\_\_\_ Chicken/Trky \_\_\_\_\_ Tofu/Soy \_\_\_\_\_ Eggs \_\_\_\_\_ Fast Food \_\_\_\_\_ Red meat \_\_\_\_\_

Fried foods \_\_\_\_\_ Dessert \_\_\_\_\_ Candy \_\_\_\_\_ Eat out \_\_\_\_\_

Drink: Green tea \_\_\_\_\_ Soda \_\_\_\_\_ Sweetened beverages \_\_\_\_\_ Coffee \_\_\_\_\_ Milk \_\_\_\_\_

How many servings a day? Vegetables \_\_\_\_\_ Fruit \_\_\_\_\_ Water (glass): \_\_\_\_\_

Food allergies/symptoms? \_\_\_\_\_

Vitamins/Supplements?

(Names/Doses) \_\_\_\_\_

**Emotional Health:**

Family? Married Significant other Divorced Live alone How long? \_\_\_\_\_

Children? Names and age: \_\_\_\_\_

Home life? Very harmonious/ Normal ups and downs/ stressful/ ready to pack my bags

Hours / week at work? \_\_\_\_\_ great job/ it pays the bills/ stressful/ want to quit

Hours of sleep per night? \_\_\_\_\_ like a log/wake up a few times/fitful/have insomnia

Several times a week I feel? overwhelmed/ stressed/ angry/ sad/ anxious/ tearful/ worried

What causes you stress right now? \_\_\_\_\_

What do you do for stress relief? \_\_\_\_\_

Do you? go to church / pray / meditate / do yoga / tai chi / qi gong / get  
acupuncture / get massage / see a therapist / exercise regularly

Religious/spiritual beliefs (if you would like to share)? \_\_\_\_\_

**Current Condition and Goals for Your Skin:**

Circle skin problems you want to address: Acne / Psoriasis / Rosacea / Eczema / Skin  
cancer /Pre-cancers / Fungus / Seborrhea (dandruff) / Seborrheic keratosis/ Lupus

Wrinkles/Scars/ dilated vessels/ blotchiness/ discoloration

Other: \_\_\_\_\_

What medications do you use for your skin? \_\_\_\_\_

Are there lesions that worry you for skin cancer? (where? symptoms?)

Are there things on your skin you would like removed? Where? \_\_\_\_\_

Are you interested in learning more about? IPL (photofacials)/ laser hair removal/ peels/  
BLU-U (acne treatment)/ Photodynamic Therapy/ Botox/ Juvederm, Restylane or other  
fillers/ fractionated light/ facials/ nurse acne clinic/ nurse wart clinic/ nurse melasma  
clinic

What would you like to make sure we discuss during your visit? \_\_\_\_\_

## **Financial Policy**

In order to establish optimal relations with our patients and avoid misunderstandings regarding our payment policies, we would like to inform you of the financial policies of this office. An initial consultation with Dr. Scheel is 45 minutes and costs \$248 plus tax. A focused visit is 25 minutes and costs \$178 plus tax. If minor procedures need to be performed such as a skin biopsy, an additional charge(s) will be incurred. If surgery needs to be done, an estimate of costs will be given during the consultation visit and we will schedule you for that procedure during your next visit. Follow-up visits are generally \$50-\$125 depending on time of visit.

*Dr. Scheel is not a provider for any insurance plans. We encourage you to contact your insurance company regarding reimbursement. If you have HMSA-HMO you will need to contact your PCP prior to your appointment and be approved through HMSA's Administrative Review process. 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). If any blood work or pathology specimens from biopsies need to be done they can be billed directly to your insurance company. Your insurance company covers prescription medications written by non-network doctors according to your drug coverage. Medicare does not reimburse for visits to our office, but your secondary insurance may cover some of your visit.*

**Payment is expected at the time of service.** We accept Visa and MasterCard, as well as checks/cash. (There is a \$25 check return fee). Cosmetic appointments require a 25% deposit on your procedure to book an appointment.

If you miss an appointment or cancel any appointment with less than 24 hours notice, you will be billed a \$50 cancellation fee and required to leave a credit card number to rebook another appointment.

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

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Signature of patient or legal guardian

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Date