REGISTRATION FORM--------WELCOME TO OUR OFFICE

PATIENT'S NAME	SOCIAL SECURITY NUMBER	SEX: MALE FEMALE	DATE OF BIRTH
MAILING ADRESS CITY STATE ZIP CODE		HOME PHONE #	WORK PHONE #

PATIENT'S EMPLOYER	EMPLOYER'S ADDRESS	PATIENT'S OCCUPATION

SPOUSE OR PARENT'S NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SPOUSE OR PARENT'S OCCUPATION

ADDRESS, IF NOT THE SAME AS PATIENT'S CITY STATE ZIP CODE	HOME PHONE #

SPOUSE OR PARENT'S EMPLOYER	EMPLOYER'S ADDRESS	WORK PHONE #

PRIMARY CARE PHYSICIAN

WHO REFERRED YOU TO OUR OFFICE?

WHO SHOULD WE CONTACT IN CASE OF EMERGENCY?
PLEASE LIST TWO CONTACTS IN ADDITION TO THE SPOUSE OR PARENT LISTED ABOVE.

NAME	RELATIONSHIP TO PATIENT	HOME PHONE #
MAILING ADDRESS CITY STATE ZIP CODE		WORK PHONE #
NAME	RELATIONSHIP TO PATIENT	HOME PHONE #
MAILING ADDRESS CITY STATE ZIP CODE		WORK PHONE #

PLEASE FILL OUT THE FOLLOWING INSURANCE INFORMATION. ALL CHARGES ARE DUE AT TIME OF SERVICE.

PERSON RESPONSIBLE FOR PAYMENT	RELATIONSHIP TO PATIENT	HOME PHONE #
MAILING ADDRESS CITY STATE ZIP CODE		WORK PHONE #

PLEASE READ AND SIGN THE INSURANCE AND TREATMENT AUTHORIZATIONS ON THE REVERSE

TREATMENT CONSENT FOR MINORS (To be completed by parent or guardian if patient is under 18 years of age):

I state that I am the legal guardian of this patient. I authorize Dr. Joseph McKinlay and/or medical staff under his direction to render medical care even if I cannot be present. I also understand that I will be responsible to pay any bills that are incurred as a result of the visits.

_____	_____	_____
SIGNATURE OF PARENT OR GUARDIAN	RELATIONSHIP TO PATIENT	DATE

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS:

I hereby authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare/Other Insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of authorized Medicare/other Insurance company benefits be made to Joseph R. McKinlay, M.D. who accepts assignment on all Medicare Claims. Regulations pertaining to Medicare assignment of benefits apply.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare/Other Insurance company assigned cases, the physician agrees to accept the charge determination of the Medicare/Other Insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/Other Insurance company. I understand that I am financially responsible for all charges incurred. I also understand that if my insurance requires a written referral or pre-authorization from my primary care physician in order to pay benefits, I am responsible to ensure that one is provided before the visit occurs(even if Dr. McKinlay's receptionist schedules an appointment with Dr. McKinlay for me) , or I will be liable for the full charges incurred. Dr. McKinlay DOES NOT PARTICIPATE with any of the Medicare HMO plans! I further acknowledge that my insurance benefits, when received by and paid to Dr. McKinlay, will be credited to my account in accordance with the above agreement.

All charges will become the patient's financial responsibility if your insurance carrier has not paid within 60 days.

If I have Medigap coverage, I request authorized Medigap benefits to be made on my behalf to Joseph R. McKinlay, M.D. for any services furnished to me. I authorize any holder of medical information to release to my Medigap carrier any information needed to determine these benefits or the benefits payable to related services.

I have been notified that Dr. McKinlay does not fill out or file any workers' compensation paperwork. I am responsible for full payment for services rendered by Dr. McKinlay even if my skin condition is work-related.

_____	_____	_____
SIGNATURE OF PATIENT (OR GUARDIAN IF PATIENT IS UNDER 18)	RELATIONSHIP TO PATIENT (IF SIGNED BY SOMEONE OTHER THAN PATIENT)	DATE

MEDICAL HISTORY

Patient: _____ Date of Birth: _____ Age: _____ Date: _____

Phone: home: _____ cell: _____ work: _____ email: _____

Reason for today's visit: _____

Please note that insurance companies and Medicare consider the removal of benign growths NOT medically necessary and DO NOT reimburse these procedures.

Are you **allergic to** any **medications**? ☐ Yes ☐ No If yes, list: _____

List all medications you are currently taking:

_____

GENERAL MEDICAL: Do you have now, or have you ever had diseases or conditions of:

	Yes	No		Yes	No		Yes	No
Asthma	☐	☐	Seizures	☐	☐	Arthritis	☐	☐
Seasonal allergies	☐	☐	Depression	☐	☐	Ulcers	☐	☐
Bronchitis/Emphysema	☐	☐	Fainting	☐	☐	Digestive/Stomach/Bowel	☐	☐
High Blood Pressure	☐	☐	Thyroid	☐	☐	Fever blisters	☐	☐
Heart Attack	☐	☐	Diabetes	☐	☐	Eczema	☐	☐
Heart Murmur	☐	☐	Hepatitis	☐	☐	Kidney/Bladder	☐	☐
Phlebitis	☐	☐	Glaucoma	☐	☐	Cancer	☐	☐
Blood clots	☐	☐	Cataracts	☐	☐	Hives	☐	☐
Blood disorders	☐	☐	Immune disorder	☐	☐	Emotional disorder	☐	☐

	Yes	No		Yes	No	
Do you smoke cigarettes?	☐	☐	? have pacemaker	☐	☐	
Have you had or have you been exposed to AIDS?	☐	☐	Do you drink alcohol?	☐	☐	How much?_____
Do you have **artificial joints**/**Heart valves**?	☐	☐	Do you take aspirin daily?	☐	☐	
Do you **bleed easily**?	☐	☐	**Are you pregnant?**	☐	☐	
Have you ever had dental anesthesia (**Novocaine**)?	☐	☐	**Any bad reaction**?	☐	☐	

List surgical procedures you have had in last 6 months: _____

List any other conditions we should know about: _____

SKIN:

Have you ever visited a dermatologist? ☐Yes ☐No Who? _____ When? _____

Reason? _____ Therapy: _____

Would you describe your CURRENT (within last 2 years) sun exposure history as: ☐Minimal ☐Moderate ☐Maximal

Would you describe your PAST sun exposure as: ☐Minimal ☐Moderate ☐Maximal

Do you actively seek a tan ('laying out' or tanning bed)?	☐Yes	☐No	
Do you regularly use sunscreen?	☐Yes	☐No	
Have you ever had skin cancer?	☐Yes	☐No	What kind? _____
Blistering sunburns?	☐Yes	☐No	
Has anyone in your family had skin cancer?	☐Yes	☐No	If yes, who? _____
Do you form keloids (thick scars)?	☐Yes	☐No	
Have you had cosmetic procedures?	☐Yes	☐No	_____

Were you happy with the results? Explain: _____

Do you have a history of any specific skin diseases? ☐Yes ☐No If yes, explain: _____

What is your ethnic ancestry (ex: Japanese, Italian)? _____

Occupation: _____ Hobbies: _____

Completed by: _____ _____

Patient/Parent(sign/date) reviewed byMD(sign/date)

Dermatology and Skin Surgery: Joseph R. McKinlay, MD 1003 Bishop St., Pauahi Tower, Ste 380 Honolulu, HI 96813