JOHN D. BOYER, MD
PATRICK M. ELLISON, MD
WESTLEY S. MORI, MD
1329 Lusitana Street, Suite 501
Honolulu, HI 96813

Legal Name: _____ Birthdate: _____ SS#: _____(For insurance)
Last First M.I.

Home Address: _____
Street # Street Name Apt City State Zip Code

Billing Address: _____

Email Address: _____

Home Phone: ( )_____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Prefer to be called (aka):_____ Military Rank/Rate: _____Active Duty or Retired Military? _____

Sex: Male or Female Marital Status: _____ Spouse's Name:_____

Patient's Occupation:_____ Patient's Employer:_____

Referring Physician: _____ Addr: _____ Phone: _____

Primary Care Physician: _____ Addr: _____ Phone:_____

Other Physician: _____ Addr: _____ Phone: _____

How did you hear about Dr. John Boyer/Dr. Patrick Ellison/Dr. Westley Mori? Other physician_____ Friend or relative____Other_____

PARENT OR RESPONSIBLE PARTY (If under 18 or different from Patient)

Name: _____ SS# _____
Last First M.I.

Address: _____
City State Zip

Home Phone: ( ) _____Work Phone: ( ) _____ Cell Phone: ( ) _____

Date of Birth _____/_____/_____ Sex: Male or Female Military Rank/Rate: _____ Active Duty or Retired?

INSURANCE INFORMATION: Please present insurance card and photo ID at time of check-in. All copayments are due at time of service.

Primary: _____	**Secondary:** _____	**Tertiary:** _____
Name of Subscriber: _____	Name of Subscriber: _____	Name of Subscriber: _____
Relation to Patient: _____	**Relation to Patient:** _____	**Relation to Patient:** _____
Subscriber's Birthdate: _____	**Subscriber's Birthdate:** _____	**Subscriber's Birthdate:** _____
Insured's Member #: _____	**Insured's Member #:** _____	**Insured's Member #:** _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process claims insurance applications and prescriptions.
I authorize payment of medical benefits to the physician.

_____ _____/_____/_____
Signature of Patient or Responsible Party Date

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PATIENT NAME: _____ **BIRTHDATE:**_____

Preferred Pharmacy Name: _____

Pharmacy Phone Number: _____

Pharmacy City or Zip Code: _____

Select any of the following medical conditions you currently have:

☐ None	☐ Human immunodeficiency virus infection
☐ Anxiety disorder	☐ Hypercholesterolemia
☐ Arthritis	☐ Hyperthyroidism
☐ Asthma	☐ Hypothyroidism
☐ Atrial fibrillation	☐ Inflammatory disease of liver
☐ Cerebrovascular accident	☐ Leukemia
☐ Chronic obstructive lung disease	☐ Malignant lymphoma (clinical)
☐ Coronary arteriosclerosis	☐ Malignant tumor of lung
☐ Depressive disorder	☐ Malignant tumour of breast
☐ Diabetes mellitus	☐ Malignant tumour of colon
☐ Elevated blood pressure	☐ Malignant tumour of prostate
☐ End-stage renal disease	☐ Radiation therapy treatment management
☐ Epilepsy	☐ Transplantation of bone marrow
☐ Gastrooesophageal reflux disease	☐ Other
☐ Hearing loss	

PLEASE PUT A CHECK MARK IF YOU GOT ANY OF THESE VACCINES:

- ○ **Influenza (Flu shot)**
  Date:
- ○ **Pneumococcal (Pneumonia)**
- ○ **Date:**
- ○ **Zoster (Shingles)**
- ○ **Date:**
- ○ **NONE**

Social History

Smoking status:	**Smoking start date**: _____
○ **Current every day smoker**	**Smoking quit date**: _____
○ **Current some day smoker**	**Alcohol Intake:**
○ **Former smoker**	○ **None**
○ **Never smoker**	○ **1 or less per day**
○ **Unknown if ever smoked**	○ **1-2 per day**
	○ **3 or more per day**

Have you had any surgeries on the following organs?

- [ ] None
- [ ] Bilateral replacement of knee joints
- [ ] Biopsy of breast
- [ ] Biopsy of prostate
- [ ] Coronary artery bypass graft
- [ ] Entire transplanted kidney
- [ ] Excision of basal cell carcinoma
- [ ] Excision of melanoma
- [ ] Excision of squamous cell carcinoma
- [ ] History of colectomy
- [ ] History of tissue graft heart valve replacement
- [ ] Mechanical heart valve replacement
- [ ] Surgical biopsy of skin
- [ ] Total replacement of left hip joint
- [ ] Total replacement of left knee joint
- [ ] Total replacement of right hip joint
- [ ] Total replacement of right knee joint
- [ ] Other

Have you had any of the following?

- [ ] None
- [ ] Acne
- [ ] Actinic keratosis
- [ ] Basal cell carcinoma of skin
- [ ] Contact dermatitis due to poison ivy
- [ ] Dysplastic naevus of skin
- [ ] Eczema
- [ ] Malignant melanoma
- [ ] Psoriasis
- [ ] Squamous cell carcinoma
- [ ] Sunburn of second degree
- [ ] Other

Do you wear sunscreen? ○ Yes ○ No

If Yes, what SPF?

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

Family History of Melanoma

Do you have a family history of Melanoma? ○ Yes ○ No

- [ ] None
- [ ] Mother
- [ ] Father
- [ ] Sister
- [ ] Brother
- [ ] Daughter
- [ ] Son
- [ ] Uncle
- [ ] Aunt
- [ ] Nephew
- [ ] Niece
- [ ] Grandmother
- [ ] Grandfather
- [ ] Grandson
- [ ] Granddaughter

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MEDICATIONS AND ALLERGIES LIST

ALLERGIES Please list ALL medication/anesthetic/latex/adhesive allergies.	REACTION (describe reaction—e.g. shock, rash, etc)

MEDICATIONS: PLEASE LIST ALL PRESCRIBED MEDICATIONS AND DOSAGE

Name of Medication	Dosage	Frequency	Reason

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Review of Systems

Symptom	Yes	No
Hay Fever		
Organ Transplant		
Cancer Chemotherapy		
CLL (Chronic Lymphoctyic Lukemia)		
Chest Pain		
Fever or Chills		
Night Sweats		
Unintentional Weight Loss		
Hearing Aid or Cochlear Implant		
Thyroid Problems		
Blurry Vision		
Abdominal Pain		
Bloody Stool		
Bloody Urine		
Joint Aches		
Muscle Weakness		
Neck Stiffness		
Headaches		
Seizures		
Fibromyalgia		
Cough		
Shortness of Breath		
Wheezing		
Anxiety		
Dementia		
Depression		
Dialysis		
ALERTS: Symptom	**Yes**	**No**
Allergy to lidocaine		
Allergy to topical antibiotic ointments		
Artificial heart valve		
Artificial joints within the past two years		
Blood thinners		
Defibrillator		
MRSA		
Oxygen use		
Pacemaker		
Premedication prior to procedure		
Rapid heartbeat with epinephrine		
Currently pregnant or planning a pregnancy		
Problems with bleeding		
Problems with healing		
History of staph infections		
Problems with scarring (hypertrophic or keloid)		
Immunosuppression		

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FINANCIAL POLICY

Thank you for choosing us. We appreciate your trust in us and the opportunity to serve you. As part of our practice, we try to offer efficient and helpful billing services. To this end, we ask you to read the following statement of our financial policy. Please sign it prior to any treatment. If you'd like to obtain a copy of this financial policy, please request a copy from the front office.

- Co-pays and deductibles are due at the time of service.
- Payment for non-covered or cosmetic procedures is due at the time of service.
- We accept cash, checks, VISA and Mastercard credit cards.
- Patients who do not have insurance are required to pay in full at the time of service. If you are not able to pay in full, please call our office to make payment arrangements.

PARTICIPATING PLANS

We will be happy to bill insurance plans we participate in. Once we receive correct payment, we will make our contractual adjustment and send you a bill for the balance due.

NON-PARTICIPATING PLANS

As a courtesy to you we will bill your insurance carrier if you provide us with complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account within 30 days, the balance will be assessed to you for payment. You should remit payment within 30 days or contact your insurance to check the status of the claim. Please notify us immediately upon contacting your insurance company or if there is anything we can do to help settle this claim. You are responsible for payment regardless of any non-participating insurance company's arbitrary determination of usual and customary rates.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best of care for our patients. Our charges are within the usual and customary charges for our specialty in our area.

PAST DUE BIILS

Please note that if your balance is unpaid for 90 days, your account will be eligible for assignment to a collection agency without further notification.
Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read, understand, and agree to this Financial Policy.

X_____ _____

Patient/Responsible Party Date

ACMS American College of Mohs Surgery

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

The signature below acknowledges that I, _____, have read and/or received a copy of
Patient Name

Dr. John D. Boyer, Dr. Patrick Ellison, and Dr. Westley Mori's Notice of Privacy Practices.

_____
Patient or Guardian Signature

_____
Date

PATIENT CONTACT AUTHORIZATION

Due to the HIPAA Privacy Act, we are only authorized to contact or speak to the individuals listed below regarding your medical information/record, appointments and scheduling, treatments, and test results.

You may:

☐ Contact me or leave a message at: _____ (Home #)

_____ (Work #)

_____ (cell/pager #)

☐ If I am unable to be reached, you may leave a message or speak with:

_____
Name Relationship to Patient Phone Number

_____
Name Relationship to Patient Phone Number

_____
Name Relationship to Patient Phone Number

In case of a medical emergency, who should be notified?

Name: _____ **Relationship:**_____**Phone:** _____

Do you have voicemail? Yes___ No___ **If so, may we leave you voicemail messages from this office?** Yes__No__

_____ _____
Patient or Guardian Signature Date