Michael R. Warner, M.D.
Laser and Cosmetic Dermatology
Mohs Micrographic Surgery

THE
COSMETIC & SKIN SURGERY
CENTER

Wyatt C. To, M.D.
Facial Plastic and Reconstructive Surgery

Registration Form

Date_____ Home Phone _____
Work Phone_____
Cell Phone_____

Patient Name_____
Last First Middle

Patient Address_____
Street/Apt# City State/Zip Code

Sex ☐M ☐F Date of Birth_____ Social Security #_____

Occupation_____ How did you hear of our practice?_____

Email address: _____ Like to receive e-Newsletters? __Yes __ No

Please list family members or other persons, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations)

Name	Relationship	Date of Birth	Phone #

Referring Physician:_____
Primary Care Physician Name & Address:_____
_____

Emergency Contact Person_____
Name Phone Number

I authorize Michael R. Warner, M.D. & Wyatt C. To, M.D. to leave messages as it pertains to my health or appointments on:

- ☐ My home answering machine
- ☐ My work answering machine
- ☐ My cell phone
- ☐ With my family members or others residing in my household

_____ _____
Signature Date

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Health Questionnaire

Name: _____ Age _____ Sex _____
Type(s) of skin cancer: ☐ basal cell ☐ squamous cell ☐ squamous cell in situ ☐ melanoma in situ
First noticed: ☐ less than a month ☐ less than six months ☐ less than a year ☐ less than five years ☐ other
Symptoms: ☐ bleeding ☐ crusting ☐ drainage ☐ itching ☐ numbness ☐ tingling ☐ pain
Previous treatments: ☐ biopsy only ☐ freezing ☐ scraping & burning ☐ excision ☐ chemical ☐ radiation
Approximate size: ☐ dime-sized or less ☐ nickel-sized ☐ quarter-sized or larger
Past personal history of skin cancer ☐ yes ☐ no If yes, what type and location _____
Please list your current medications: ☐ none

_____

_____

Please list all allergies: ☐ none

_____

Are you allergic to: ☐ latex ☐ local anesthetics ☐ antibiotics ☐ adhesive tape? ☐ No
Do you take ☐ aspirin ☐ ibuprofen (Aleeve, Advil, etc.) ☐ vitamin E? ☐ No
Do you take ☐ Coumadin (warfarin) ☐ Plavix ☐ Trental ☐ Ticlid? ☐ No
Do you take herbal remedies? ☐ N ☐ Y Please list: _____
Do you drink alcohol? ☐ Y ☐ N
Do you smoke? ☐ Y ☐ N
Please check yes or no:

Pacemaker	☐ Y ☐ N	Mitral valve prolapse	☐ Y ☐ N	Leukemia	☐ Y ☐ N
Defibrillator	☐ Y ☐ N	Heart valve disease	☐ Y ☐ N	HIV	☐ Y ☐ N
High blood pressure	☐ Y ☐ N	Artificial joint	☐ Y ☐ N	Hepatitis	☐ Y ☐ N
Heart attack	☐ Y ☐ N	Other prosthetic	☐ Y ☐ N	Liver disease	☐ Y ☐ N
Stroke or mini-stroke	☐ Y ☐ N	Organ transplant	☐ Y ☐ N	Kidney disease	☐ Y ☐ N
Deep vein thrombosis	☐ Y ☐ N	Diabetes	☐ Y ☐ N	Psychiatric disorder	☐ Y ☐ N
Pulmonary embolism	☐ Y ☐ N	Thyroid disease	☐ Y ☐ N	Keloids	☐ Y ☐ N
Atrial Fibrillation	☐ Y ☐ N	Lymphoma	☐ Y ☐ N	Other:	

Do you take prophylactic antibiotics prior to seeing the dentist or prior to having surgery? ☐ Y ☐ N
Are you pregnant or trying to become pregnant? ☐ Y ☐ N
Please check yes or no:

Back pain	☐ Y ☐ N	Bowel problems	☐ Y ☐ N	Eye pain	☐ Y ☐ N
Chest pain	☐ Y ☐ N	Wheel chair	☐ Y ☐ N	Vision problems	☐ Y ☐ N
Trouble lying back	☐ Y ☐ N	Shortness of breath	☐ Y ☐ N		

Other comments: _____

Have you had a communicable disease in the past six months? ☐Y ☐N

If yes, please explain:

_____

_____

Please sign your name and date, indicating that the above information is true and complete to the best of your knowledge:

_____
Signature Date

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Insurance Form

Patient Name: _____ Date _____
Last First Middle

Social Security Number _____

Do you have Medical Insurance? □ No □ Yes:

Primary Insurance Carrier

_____
Name

_____
Member Identification Number

_____
Group Number

Secondary Insurance Carrier

_____
Name

_____
Member Identification Number

_____
Group Number

PLEASE NOTE: All charges or co-payments are due at the time of service, when applicable. **Please present your insurance card(s) and driver's license to the office staff with this completed form.** We will copy them for our records and return them to you immediately. We reserve the right to add reasonable collection fees on any account over 60 days past due.

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with_____
Name of Insurance Company

And assign directly to Michael R. Warner, M.D, P.A. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured or Guardian or POA Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Michael R. Warner, M.D., P.A. for any services furnished me by their physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier 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 carrier.

_____ _____
Beneficiary Signature Date

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MICHAEL WARNER, M.D., P.A.
Office Policy Information Sheet

OUR PRACTICE FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

Unless other arrangements have been made in advance by either yourself or your health coverage carrier, full payment is due at the time of service.

YOUR INSURANCE

We will be happy to bill your insurance carrier for you; however any copayment/coinsurance is due at the time of service. In some circumstances we will request a prepayment for services. In the event your health plan determines a service to be "not covered," you will be responsible for the complete charge. In that event we will bill you, and payment is due upon receipt of that statement.

MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

RETURNED CHECKS

It is our office policy to charge a fee of $25.00 for any returned checks.

COMPLETION OF FORMS

We will be happy to complete insurance/disability forms for our patients; however our fee for this service is $10.00 per form.

DELINQUENT ACCOUNTS

We reserve the right to add reasonable collection fees to any account over 60 days past due.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____
Signature of Patient or Responsible Party if a Minor Date

_____ _____
Signature of Co-responsible Party Date

_____
Please Print the Name of the Patient