Office of John D. Boyer, M.D. / Patrick M. Ellison, M.D. / Westley S. Mori, M.D.
1329 Lusitana Street, Suite 501, Honolulu HI 96813

Patient Name: _____ Birthdate: _____

Preferred Pharmacy: _____ Pharmacy City/Zip: _____

MEDICAL HISTORY: *Select the following medical conditions you currently have:*

- ☐ NONE
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Cerebrovascular accident
- ☐ Chronic obstructive lung disease
- ☐ Coronary arteriosclerosis
- ☐ Depressive disorder
- ☐ Diabetes
- ☐ Elevated Blood Pressure
- ☐ End-stage renal (kidney) disease
- ☐ Epilepsy
- ☐ Gastro-esophageal reflux disease (acid reflux)
- ☐ Hearing loss
- ☐ Human Immunodeficiency virus
- ☐ Hypercholesterolemia (high cholesterol)
- ☐ Hyperthyroidism (high thyroid)
- ☐ Hypothyroidism (low thyroid)
- ☐ Inflammatory disease of the liver
- ☐ Leukemia
- ☐ Malignant lymphoma (clinical)
- ☐ Malignant tumor of lung
- ☐ Malignant tumor of breast
- ☐ Malignant tumor of colon
- ☐ Malignant tumor of prostate
- ☐ Radiation therapy treatment management
- ☐ Transplantation of bone marrow
- ☐ Other

SOCIAL HISTORY:

Do you smoke?

- ☐ Never smoker
- ☐ Former smoker
- ☐ I smoke/vape daily
  (Brochure provided by MOHS staff. ☐)

Do you have an Advanced Care Plan? (ex. Living will, power of atty, Do Not Resuscitate, etc.)

- ☐ **I have a current Advance Care Plan.**
  (Copy provided for our office. ☐)
- ☐ **I need a new ACP form.**
  (ACP forms provided by MOHS staff. ☐ Patient declined form ☐)

Do you feel depressed?

Do you feel nervous, anxious, or on edge?	☐ Never	☐ Rarely	☐ Nearly every day
Not being able to stop or control worrying?	☐ Never	☐ Rarely	☐ Nearly every day
Feeling down, depressed or hopeless?	☐ Never	☐ Rarely	☐ Nearly every day
Little interest or pleasure in doing things?	☐ Never	☐ Rarely	☐ Nearly every day

(Brochure provided by MOHS staff. ☐)

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PAST SURGERIES: Have you had any surgeries on the following organs?

- ☐ NONE
- ☐ 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
- ☐ Replacement of **left hip** joint
- ☐ Replacement of **left knee** joint
- ☐ Replacement of **right hip** joint
- ☐ Replacement of **right knee** joint
- ☐ Other: _____

MEDICAL CONDITIONS: *Have you had any of the following:*

- ☐ NONE
- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Basal cell carcinoma of skin
- ☐ Contact dermatitis caused by urushiol from Eastern poison ivy
- ☐ Dysplastic naevus of skin (abnormal moles)
- ☐ Eczema
- ☐ Malignant melanoma
- ☐ Psoriasis
- ☐ Squamous cell carcinoma
- ☐ Sunburn of second degree
- ☐ Other skin problems: _____

Do you wear sunscreen? ☐ No ☐ Yes - *If yes, what SPF?* _____

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

FAMILY HISTORY OF MELANOMAS:

- ☐ ***NO family history of melanomas***
- ☐ ***Unknown***
- ☐ Mother
- ☐ Father
- ☐ Grandmother (M/P)
- ☐ Grandfather (M/P)
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Grandson
- ☐ Granddaughter
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece

MEDICATIONS AND ALLERGIES:

*Please list ALL your **allergies** and reactions:*

ALLERGEN *(list all medications, anesthetics, latex, adhesives, etc.)*	**REACTION** *(describe reaction: shock, rash, shortness of breath, etc.)*

*Please list ALL your **prescribed medications** and dosages.*

NAME OF MEDICATION	DOSAGE	FREQUENCY	REASON

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REVIEW OF SYSTEMS: *Mark **Yes** indicating symptoms you are **CURRENTLY** experiencing – Mark **No** confirming you are not experiencing any symptoms:*

SYMPTOM	YES	NO	SYMPTOM	YES	NO
Alerts: symptom			*Currently pregnant or planning a pregnancy*		
Fever or chills			*Headaches*		
Hay fever			*Seizures*		
Hearing aid or cochlear implant			*Anxiety*		
Blurry vision			*Dementia*		
Cough			*Depression*		
Shortness of breath			*Problems with scarring (hypertrophic or keloid)*		
Wheezing			*Joint aches*		
Oxygen use			*Muscle weakness*		
Chest pain			*Neck stiffness*		
Artificial heart valve			*Cancer chemotherapy*		
Defibrillator			*Chronic Lymphocytic Leukemia*		
Pacemaker			*Immunosuppression*		
Rapid heartbeat with epinephrine			*Dialysis*		
Organ transplant			*Blood thinners*		
Abdominal pain			*Problems with bleeding*		
Bloody stools			*Problems with healing*		
Bloody urine			*MRSA*		
Night sweats			*Allergy to lidocaine*		
Unintentional weight loss			*Allergy to topical antibiotic ointments*		
Thyroid problems			*History of staph infections*		
Fibromyalgia			*Premedication prior to procedure*		

ACMS American College of Mohs Surgery

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_____

Is this visit(s) related to worker's compensation? _____ YES _____ NO

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.

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

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. **We DO NOT accept workers' compensation.**

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**

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.

X_____
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 on my behalf:

_____
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__

X_____ _____
Patient or Guardian Signature Date