

NICHOLS

MOHS AND SKIN SURGERY

INCOMPLETE

Welcome to **Nichols Mohs and Skin Surgery.**

Enclosed you will find several forms to complete prior to your appointment. After reading and completing the forms, you may fax them to (573) 876-1000. **Even if you fax them in advance, please be sure to bring them with you on your appointment day.**

The enclosed forms include:

- Patient information form
- Medical history form
- Signature form for Privacy Policy (HIPAA), Financial Policy, and Release of Medical Information

Along with the enclosed forms, please bring the following to your appointment:

- Insurance card
- Co-pay or Deductible

If you should have any questions regarding your appointment, insurance coverage or the Mohs procedure, please contact our office at (573) 876-1000.

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PATIENT INFORMATION

Last Name _____

First Name _____ MI _____

Nickname or Maiden Name _____

Address _____

PO Box _____

City _____

State _____ Zip Code _____

Home Phone _____

Cell Phone _____

Work Phone _____ Extension _____

E-mail _____

Date of Birth _____ Male Female

Social Security Number _____

Occupation _____

Employer Address _____

Employer City _____

Employer State _____ Zip Code _____

Marital Status Single Married Partner
 Divorced Separated Widowed

Spouse's Name _____

Spouse's Phone _____

REFERRAL INFORMATION

Primary Care Physician _____

Referring Physician _____

INSURANCE AND PAYMENT INFORMATION

Method of payment Self pay Patient IS the policy holder Patient IS NOT the policy holder
Secondary Insurance _____

Primary Insurance _____

ID/Policy Number _____

Group Number _____

Employer _____

RESPONSIBLE PARTY

This is the person who will receive statements, and will be responsible for balance not covered by insurance (if different from patient).

Name _____

Address _____

PO Box _____

City _____

State _____ Zip Code _____

Home Phone _____

E-mail _____

NOTIFY IN EMERGENCY

If your spouse can not be reached, this person will be contacted in case of an emergency.

Name _____

Address _____

City _____

State _____ Zip Code _____

Phone _____

Phone alt _____

Relationship to patient _____

PHARMACY INFORMATION

Name _____

Location _____

Phone _____

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MEDICAL HISTORY

Patient _____

Appointment Date _____

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RELEASE OF MEDICAL INFORMATION

FINANCIAL POLICY

PRIVACY PRACTICES

INCOMPLETE