DERMATOLOGY CENTER
OF THE EAST BAY

PATIENT REGISTRATION

PATIENT INFORMATION (please use your legal name)

Last Name	First Name	Middle Name	❑ Mr ❑ Mrs ❑ Miss ❑ Ms ❑ Dr ❑ Single ❑ Married ❑ Widowed

Other Names Used (if any)	Date of Birth	Age	❑ Male ❑ Female ❑Sie ❑Zie ❑They	Race: _____ Ethnicity: _____ Preferred Language: _____

Street Address	City	State	ZIP Code

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

Is it okay to leave a voice message for the communication of detailed test results? ❑ Yes ❑ No If yes, what is your preferred number? ❑ Home ❑ Cell ❑ Other ( )	Would you like for us to be able to discuss your personal health information with any of your friends or relatives? ❑ Yes ❑ No If yes, please specify with whom:
Occupation and Employer	Primary Care Physician
Did a physician request that you seek a consultation with a dermatologist? ❑ Yes ❑ No	If yes, what is the name of the physician and the reason for the consultation?

Please list any family members who are seen in this practice:

Would you like access to our online patient portal? ❑ Yes ❑ No

The Patient Portal is a system that allows for you to access and update your records. You can also view summaries of your office visits, as well as information on your diagnoses and treatment plans.

If yes, please provide your email address: _____

PREFFERED PHARMACY

Please fill in as much information about your pharmacy as you can:

Name: _____
Address: _____
_____
Phone #: _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative: Relationship:

Phone #: ( )

HEALTH HISTORY/MEDICAL INFORMATION

Do you have a history of any of the following medical conditions? Select all that apply:

- ❑ anxiety
- ❑ arthritis
- ❑ atrial fibrillation (irregular heartbeat)
- ❑ asthma
- ❑ bone marrow transplant
- ❑ breast cancer
- ❑ cirrhosis of the liver
- ❑ colon cancer
- ❑ COPD (lung disease)
- ❑ coronary artery disease
- ❑ Crohn's disease
- ❑ depression
- ❑ diabetes
- ❑ end stage renal disease
- ❑ hepatitis B
- ❑ hepatitis C
- ❑ HIV/AIDS
- ❑ prostate cancer
- ❑ radiation treatment
- ❑ seizures
- ❑ stroke
- ❑ ulcerative colitis
- ❑ polycystic ovarian syndrome
- ❑ lupus
- ❑ problems healing
- ❑ keloids or thick scars
- ❑ other :

For Women: Are you pregnant? ❑ Yes ❑No	Planning a pregnancy? ❑ Yes ❑ No	Breastfeeding? ❑ Yes ❑ No

Past surgeries. Select all that apply

- ❑ Joint replacement
  Which joint? _____
  When? _____
- ❑ Organ Transplant
  Which organ? _____
  When? _____
- ❑ Heart: Pacemaker
- ❑ Heart: defibrillator
- ❑ Heart: valve replacement
  Circle: mechanical or biological
- ❑ Heart: Coronary artery bypass
- ❑ Heart: balloon angioplasty (PTCA)
- ❑ Heart: stent placement
- ❑ Skin: squamous cell carcinoma
- ❑ Skin: melanoma
- ❑ Skin: cancer unknown
- ❑ Skin: Mohs surgery
- ❑ Others:

Have you had any of the following skin conditions? Select all that apply:

- ❑ acne
- ❑ actinic keratoses
- ❑ asthma
- ❑ basal cell skin cancer
- ❑ blistering sunburns
- ❑ dry skin
- ❑ eczema
- ❑ flaking or itchy scalp
- ❑ hay fever/allergies
- ❑ melanoma
- ❑ poison oak/ivy
- ❑ precancerous moles
- ❑ psoriasis
- ❑ squamous cell skin cancer
- ❑ other:

Do you wear sunscreen? ❑ Yes ❑No If yes, what SPF? _____ Do you tan in a tanning salon? ❑ Yes ❑No ❑ Not anymore

Do you have a family history of MELANOMA? ❑ Yes ❑No ❑Unknown

If yes, which relative? _____

List of current medications and dosage (if known):

- ❑ None
- ❑ Ibuprofen
- ❑ Aspirin
- ❑ Naproxen
- ❑ Coumadin/warfarin
- ❑ Plavix
- ❑ Vitamin E
- ❑ Fish oil
- ❑ Other: Please list all other over-the-counter medicines, vitamins/supplements, and prescriptions

Allergies. Select all that apply:

- ❑ No known drug allergies
- ❑ Allergy to adhesive
- ❑ Allergy to lidocaine
- ❑ Allergy to antibiotic ointments
- ❑ Allergy to medications
- ❑ Allergy to other

Please list medication allergy and reaction below:

Social History Details

Please select smoking status: ❑never smoker ❑former smoker ❑current every day smoker ❑current same day smoker

Please select alcohol usage: ❑none ❑less than 1 drink per day ❑1-2 drinks per day ❑3 or more drinks per day

Other recreational drug use:

Are you currently experiencing any of the following? Select all that apply:

- ❑ Weakness
- ❑ Changing moles
- ❑ Rash
- ❑ Problems with healing
- ❑ Problems with scarring
- ❑ Problems with immunosuppression
- ❑ Hayfever
- ❑ Chest pain
- ❑ Fever or chills
- ❑ Night sweats
- ❑ Unintentional weight loss
- ❑ Thyroid problems
- ❑ Sore throat
- ❑ Mouth lesions
- ❑ Blurry vision
- ❑ Abdominal pain
- ❑ Bloody stool
- ❑ Nausea
- ❑ Diarrhea
- ❑ Bloody urine
- ❑ Genitourinary problems
- ❑ Swollen or enlarged lymph nodes
- ❑ Joint aches
- ❑ Muscle weakness
- ❑ Neck stiffness
- ❑ Headaches
- ❑ Seizures
- ❑ Dizziness
- ❑ Anxiety
- ❑ Depression
- ❑ Cough
- ❑ Shortness of breath
- ❑ Wheezing

Are you interested in any of the listed procedures or in treatment of any of the following? Select all that apply

- ❑ Skin tightening
- ❑ Laser skin resurfacing
- ❑ Laser treatment for brown spots
- ❑ Laser treatment for red spots
- ❑ Skin discoloration
- ❑ Botulinum toxin
- ❑ Fillers
- ❑ Removal of skin lesions
- ❑ Wrinkles
- ❑ laser hair reduction
- ❑ Scars
- ❑ Aging skin
- ❑ Leg veins
- ❑ minimally invasive fat removal
- ❑ Other:

SIGNATURE

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize my physician or my insurance company to release any information required to process my claims. If patient is a minor, this form must be signed by a legal guardian.

X_____

Patient/Guardian Signature Print Name Here Date

OFFICE FINANCIAL POLICY

Patient Name _____ Insurance _____

Our goal is to provide and maintain a good physician-patient relationship. Letting you know of our financial policy in advance allows for a good flow of communication and enables us to achieve our goal. If you are a returning patient, please consider this a reminder and thank you for continuing your care with our office.

- If we are contracted providers of your insurance:

    1. We will bill your insurance for all covered services
    2. You are expected to pay your copay and any non-covered services at the time of service
    3. You are responsible to pay all deductibles and co-insurance amounts

- If we are not contracted with your insurance:

    1. Payment is expected at the time of service

- For Self-Pay and Cosmetic Services:

    1. You will be expected to pay at the time of service

I understand that I am responsible for knowing the terms of my insurance policy. If I choose to have any service done that is not covered by my insurance, I understand that I will be responsible for payment of the services that I have incurred. I also understand that it is my responsibility to know if a written referral is required to see a specialist, if pre-authorization is required prior to a procedure, and what services are covered.

I understand that I am responsible to provide a current insurance card at the time of service. I understand that I will be responsible for payment of the visit should I fail to do so in a timely manner.

If I am covered by Medicare and am provided notice, in advance, that certain procedures will not be covered, I understand that I will be responsible to pay for the incurred charges.

I understand patient balances are billed monthly after receipt of my insurance plan's explanation of benefits and are due upon receipt of my bill.

I understand that I have a contractual obligation with my insurance company to pay any copayments at the time of service.

I have read the above policies and agree to the terms.

Signature: _____ *Date:* _____

Your copayment or balance may be paid by cash, check, Visa or Mastercard. Please feel free to discuss billing concerns and questions with the Office Manager.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, the physician originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

1. A basis for planning my care and treatment
2. A means of communication among the many healthcare professions who contribute to my care
3. A source of information for applying my diagnosis and surgical information to my bill
4. A means of which a third-party payer can verify that billed services were actually provided
5. A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals, and/or governmental mandated follow-up of some types of skin cancer surgery

I understand that I have the right:

1. To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the practice is not required to agree to the restrictions requested.
2. To revoke this consent in writing, except to the extent that the practice has already taken action reliance there on

I hereby acknowledge that I have been presented with a copy of the physician's notice of privacy practices.

_____

Patient's Name Patient's Date of Birth

_____

Preferred phone number, w/ voicemail, for communications of detailed test results

_____

Signature of Patient or Legal Representative Date

CANCELLATION / NO SHOW POLICY

PLEASE READ THIS NOTICE CAREFULLY

Thank you for choosing our clinic as your dermatologic provider. In order to offer our patients the greatest flexibility in scheduling and timely access to care, we have implemented a CANCELLATION / NO SHOW POLICY.

General dermatology, laser/cosmetic procedures, and Mohs micrographic surgery are provided here in our clinic. We very much value our patients. However, failure to notify our office of any cancellation means we cannot offer that time to other patients. For this reason, we must enforce a fee for a “no show” or a cancellation made less than 24 hours prior to your appointment.

General and cosmetic dermatology office visits: $50
Mohs micrographic surgery: $250

Please remember to arrive early for your appointment. To prevent prolonged wait times, if you are more than 10 minutes late, we may have to reschedule your appointment to a later date. We understand that on occasion a situation may arise that requires you to cancel your appointment last minute or miss your appointment altogether. Please let us know if you have any extenuating circumstances that prevent you from being able to comply with our policy. We appreciate your cooperation in this matter.

I have read the Cancellation / No Show Policy. I fully understand my financial responsibility to this office.

Print Patient Name: _____ Date: _____

Signature of Patient or Responsible Party: _____