PATIENT INFORMATION

(Please complete all sections)

Date: _____ **Office Location:** _____

PATIENT NAME (*Last, First M.I.*):_____ **DATE OF BIRTH:** ___/____/_____

NAME OF PARENT(S) OR GUARDIAN(S): _____ **SSN#:** _____

_____

SEX: ◯ *Male* ◯ *Female* **MARITAL STATUS:** ◯ *Single* ◯ *Married* ◯ *Divorced* ◯ *Widowed* ◯ *Separated*

MAILING ADDRESS:

STREET: _____ CITY: _____ STATE:_____ZIP_____

HOME PHONE: (____) _____**WORK:** (____) _____ **CELL:** (___) _____

RELATION TO INSURED: ◯ *SELF* ◯ *SPOUSE* ◯ *CHILD* ◯ *STEP CHILD* ◯ *OTHER*

PRIMARY CARE PHYSICIAN: _____ **PHONE #:** (____) _____

PHARMACY: _____ **PHONE #:** (____) _____

HOW DID YOU HEAR ABOUT ADVANCED DERMATOLOGY? _____

PARENT, SPOUSE, OR RESPONSIBLE PARTY

If Different from Patient

NAME (*Last, First M.I.*):_____ **DATE OF BIRTH:** _____/_____/_____

SSN#: _____ **SEX:** ◯ *Male* ◯ *Female*

MAILING ADDRESS:

STREET: _____ CITY: _____ STATE:_____ZIP_____

HOME PHONE: (____) _____**WORK:** (____) _____ **CELL:** (___) _____

Please list everyone that you authorize us to share information regarding your care:

(for instance children, parents, or partners who can receive test results, etc.)

****LEAVE BLANK IF WE ARE ONLY TO SHARE INFORMATION WITH THE PATIENT****

Name: _____ *Relationship:* _____ *Contact #:* (_) _____

Name: _____ *Relationship:* _____ *Contact #:* (_) _____

Name: _____ *Relationship:* _____ *Contact #:* (___) _____

I agree that the names I listed above can receive any information on my behalf regarding my medical records, results, etc.

_____ ***(initial here)***

WOULD YOU LIKE TO LEARN MORE ABOUT OUR COSMETICS? ◯ ***YES*** ◯ ***NO***

If *Yes*, Please describe what you would like information on: _____

TO BE FILLED OUT BY OFFICE:

Primary: INS CARRIER: _____ ID# _____ MEDICAL GROUP: _____ COPAY: _____

Secondary: INS CARRIER: _____ ID# _____ MEDICAL GROUP: _____ COPAY: _____

MEDICAL QUESTIONAIRE

Date: _____

NAME (*Last, First M.I.*):_____ **DATE OF BIRTH:** _____/_____/_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

YES	NO	
◯	◯	Skin Cancer/Melanoma
◯	◯	Acne/ Accutane
◯	◯	Cold sores
◯	◯	Keloids/ Bad scars
◯	◯	Eczema/ Skin Rashes
◯	◯	Difficulty with wound healing
◯	◯	Difficulty with skin infections
◯	◯	Psoriasis
◯	◯	Asthma/ Hay Fever/ Hives/ Sinus Issues
◯	◯	Rheumatic Fever
◯	◯	Heart Disease
◯	◯	High Blood Pressure
◯	◯	Heart Murmur/ Mitral Valve Prolapse
◯	◯	Artificial Joint, Heart valve, Prosthesis
◯	◯	Pacemaker or Defibrillator
◯	◯	Kidney Disease
◯	◯	Glaucoma
◯	◯	Diabetes
◯	◯	Tuberculosis
◯	◯	Blood-Bourne Infections
◯	◯	Autoimmune Disease (Lupus, Rheumatoid Arthritis)
◯	◯	Hepatitis B OR C (Please Circle)

Blood Transfusions	
Dates:	

Surgery / Hospitalizations:	
DATE:	Opreation Type:

YES	NO	Have Any Blood Relatives Had Any Of The Following:
◯	◯	Skin Cancer
◯	◯	Melanoma
◯	◯	Asthma/ Hay Fever
◉	◯	Eczema/ Skin Rashes
◯	◯	Diabetes
◯	◯	Psoriasis
◯	◯	Other Skin Disease:

Are you Allergic To any Medications? _____

_____

_____

_____

Do you have sensitivity to Lidocaine or Epinephrine? ◯ ***YES*** or ◯ ***NO***

Are you Currently Taking Medications or Vitamin/Mineral Supplements? (PLEASE LIST) ***IF NONE, CHECK HERE*** ☐

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

YES	NO	OTHER QUESTIONS
◯	◯	Are you in good health?
◯	◯	Do you sunbathe?
◯	◯	Do you use Tanning Booths?
◯	◯	Do you need Antibiotics ***before*** Dental Surgery?
◯	◯	Do you Bleed easily?
◯	◯	Are you inder the care of a Physician
		If YES, Please List Conditions:

YES	NO	FOR FEMALE CLIENTS ONLY
◯	◯	Are You Pregnant?
◯	◯	Are you Nursing?
◯	◯	Do you take Birth-Control?
		If *YES*, name:
		Date of Last Menstrual Period:
		____/____/_____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

NOTICE OF PRIVACY PRACTICIES

Notification is hereby given that Advanced Dermatology shall not reveal or disseminate any personal information about you or your dependents without your permission. Your information shall never be sold, or listed for purpose of advertising, fundraising or solicitation.

I, _____ *(Patient/ Patient's Representative)* do understand that within the context of doing business and providing general healthcare services, my personal information will be necessary and vital and may be used in the following ways:

- Patient Registration.
- Obtain medical records from previous physicians and/or ancillary medical providers.
- Consultation with other medical providers as may be necessary for medical care and/or treatment options.
- Insurance verification and billing matters. Including interaction with billing company, insurance companies and other necessary and proper related matters.
- Pursuit of unpaid medical bills and collection of unpaid medical bills.
- Office staff, medical assistants, physicians.
- Emergency medical services (Fire, Paramedic, Police, and Hospital Staff) in the event such a need may arise.
- Personal religious designate
- Completion of disability forms
- Computer and electronically stored information (including business vendors and service personnel)

In the event you desire a copy of this Notice of Privacy Practice you may contact Advanced Dermatology and skin cancer specialists at the following:

Advanced Dermatology and Skin Cancer Specialists

Corporate Office

Tel: 951.303.6900

Fax: 951.303.2900

31720 S. Temecula Pkwy Suite #203

Temecula CA 92592

I have read the Notice of Privacy Practices and hereby authorize the release of this necessary information:

_____ _____

Patient/Patient Representative *(Signature)* **Date:**

_____

Patient/ Patient Representative *(Print Name)*

MEDICAL RECORDS RELEASE FORM

Authorization for use or Disclosure of Protected health Information

As required by the health information Portability and Accountability Act of 1996(HIPPA) and California Law, Advanced Dermatology and Skin Cancer Specialists, may not use or disclose your individual identifiable health information except as provided in our notice of privacy practices without your authorization. Your completion of this forms means that you are giving your permission for the use disclosures described below. Please be aware that once your information leaves Advanced Dermatology and Skin Cancer Specialists, we will no longer be able to protect that information, and the recipients of your information may not be legally required to protect your information.

I hereby, release Advanced Dermatology and Skin Cancer Specialists from any/all legal liability that may arise from the release of this information to the party listed below. Further, I authorize Advanced Dermatology and Skin Cancer Specialists to obtain or disclose health information concerning:

Patient Name: _____ **Date of Birth:** ____/____/____

Health Information to be released or Disclosed

☐ **History/ Physical Exams**
☐ **Entire Medical Records**
☐ **Progress Notes**
☐ **Telephone Messages**
☐ **Consultation Report**
☐ **Biopsy/ Surgical Pathology Site** _____
☐ **Lab Results**
☐ **X-Ray Results**

I understand this information may include information relating to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, STDs (Sexually Transmitted Diseases), and treatment for alcohol and/or drug abuse.

Please make sure that all physician or contact information is filled out completely. Requests with missing information will not be honored.

_____**Initial**

Information to be released to:

_____
_____
_____

From:

_____
_____
_____

I understand this authorization may be revoked in writing at any time, according to Advanced Dermatology and Skin Cancer Specialist Notice of Privacy Practices. Unless otherwise revoked, this authorization will expire One year from date of this authorization.

Printed Name: _____ **Date:** ____/____/____

Signature: _____ **Witness:**_____

If signed by other than the patient, indicate the relationship: _____

ADVANCED DERMATOLOGY & SKIN CANCER SPECIALISTS
ACKNOWLEDGMENT OF INSURANCE

Patient's Name: _____ **Date of Birth:** ____/____/____

I am enrolled in: _____ **With:** _____
(Name of insurance company) *(Medical Group)*

I understand that IF I am *no longer eligible* with the above-named insurance or that my insurance has changed or been terminated, or if I have other primary insurance that I have not provided - I or the person who is financially responsible for me, will assume full responsibility for all charges incurred by myself.

If HMO: I am aware that my HMO requires me to be assigned to a PCP and have authorization prior to service. If I am not assigned to this office/doctor, I or the person financially responsible for me will assume full responsibility for all charges incurred by myself.

If IEHP: Do you have other insurance? Yes ◯ No ◯ (Is your child/self-covered by another insurance?)

If MEDICARE:
Medicare DIRECT: ☐ Medicare HMO: ☐ MEDICAL GROUP: ☐ Medicare PPO Advantage: ☐
(A COPY OF YOUR CURRENT MEDICARE CARD MUST BE ON FILE)

I AGREE THAT IF THE ABOVE INFORMATION IS NOT TRUE, I OR THE PERSON WHO FINANCIALLY RESPONSIBLE FOR ME WILL PAY IN FULL ALL SUCH CHARGES.

Patient/ Responsible Party Signature: _____

Date: ____/____/____