PATIENT INFORMATION

Date_____

Patient Name_____

Date of Birth_____/_____/_____ Age_____

Address_____ City_____Zip_____

Home Phone Number_____Cell phone Number _____

Email Address_____.

How did you hear about us?_____

Doctor's Name, if you were referred_____

Social Security Number _____-_____-_____

Your preferred pharmacy name_____Phone Number_____

Insurance Name_____Secondary Insurance Number _____

Member ID_____ Group _____

Policy Holder_____Policy Holder's SSN_____

What is your relationship to policy holder? Self_____Spouse_____ Child_____Other_____

Emergency Contact _____Phone _____

301 W. Huntington Dr. Suite 215
Arcadia CA 91007

NOTICE OF PRIVACY PRACTICES

HIPAA, the Health Insurance Portability Act of 1996 had recently been formalized and will help govern the relationship between patients and their providers of Health Care to provide all entitled Medical Services in the most efficient way.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU, AS THE PATIENT, MAY GET ACCESS TO THIS INFORMATION.
Please read and Review it Carefully

If you have any question about this notice, please contact our office directly. **We appreciate the trust that patients place in us and we recognize the importance of** protection the confidentiality of non-public personal information that we have in our possession. This information will be used only to ensure accuracy in carrying out treatments for you and in keeping your records. In conduction transactions with patient's health carries or affiliates they designate, we will always endeavor to use information that is absolutely necessary to comply. If we change this policy, we will notify you in advance.

This notice describes the information privacy practices that are followed by our employees, physicians and all other office personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care/services you receive at this office. It also reviews the ways in which your health information may be disclosed to other entities and it describes your rights and our obligations in managing the privacy and integrity of your care. We are required by law to give you this notice and to help you understand its intent. You must signify your understanding and agreement by signing in the appropriate spaces. You may opt out of this agreement at any time by presenting this office with written notice of your wishes.

Patient or Guardian Signature	Date
Print Name	Date of Birth
Witness	Date

OFFICE & FINANCIAL POLICIES

Welcome and thank you for choosing Center for Advanced dermatology for your dermatology care. We are committed to the highest professional standards of skin care while providing patients with a comfortable and friendly environment. We hope that by providing you with our policies in advance we can prevent any misunderstandings during your time with us.

Patient Initial

_____**Insurance:** When making an appointment, it is your responsibility to confirm with your insurance company (or companies if you have a secondary policy) that the physician is currently under contract with your plan. Each plan has its own stipulations regarding the coverage of, and payment for, medical services; therefore it is your responsibility to know your plan's benefit policies including co-payments, prior to your appointment. Ultimately all insurance deductibles, co-payments, and denials for primary or secondary insurance policies will be your financial responsibility.

_____**Medicare/Medical Patients Only:** We are not under contract with Medical; therefore whatever Medicare does not cover will be the financial responsibility of the patient.

_____**Check-in:** We do our best to keep on schedule, so please arrive for your appointment on time. If you arrive more than 20 minutes past your scheduled appointment time, you will be rescheduled so that other patients are not inconvenienced. Please bring your current insurance card(s) with you to your first visit. On subsequent visits, it will be your responsibility to notify us of any changes in your address and/or insurance information; otherwise, you will be responsible for any omissions, financial or otherwise, related to these changes.

_____**Copays/Outstanding Balances:** Please be prepared to pay any past balances on your account. Payment of co-pays and non-covered services will be required at time of service. For your convenience, we accept cash, checks for amounts under $500, MasterCard, Visa, and Discover Card.

_____ **Out-of-Network**: If your insurance is with a company that our office does not contract with, you must pay for your services at the time of service.

_____ **Non-covered Services**: If you are coming for a non-covered service, please be prepared to pay for the service in full at the time of service. Cosmetic procedures including, but not limited to, sclerotherapy**,** Botox, laser procedures, hair reduction, photorejuvenation, chemical peels, dermabrasion and fillers are not covered by insurance and claims will not be filed for them.

_____ **Refunds/Exchanges**: Partial refunds for incompletely used cosmetic packages may be given within 30 days of purchase. No refunds will be given after 30 days; however, any unused balance may be applied towards other services and/or products. Products may be returned for a full refund within 30 days of purchase if unopened and in their original packaging.

_____**NO SHOWS and Late Cancellations**: We require a 24-hour advance notice if you must cancel your appointment. Each patient is allowed one NO SHOW or late cancellation. Any NO SHOW or late cancellation thereafter will result in a $75 charge.

I_____ **Minors:** The parent(s) or guardian(s) must accompany a minor for their first visit to our office, and are responsible for providing current insurance information and/or payment in full for services provided. For follow-up visits, unaccompanied minors must have an authorization note for medical treatment signed by a parent or guardian before treatment can be rendered.

I have read, understand and agree to the above office and financial policies. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize release of information as necessary for insurance filing and precertification by signing this statement.

_____DOB:_____

Patient Name

_____Date:_____

Signature of Patient or Responsible Party

Dermatology Medical History

Patient: _____ Date of Birth: ___/_____/_____ Today's date: ___/_____/_____

Reason for today's visit: _____

Are you allergic to any medication? ☐ Yes ☐ No If yes, list below:

1. _____ 2. _____

Have you ever had dental anesthesia (Novocaine)? ☐ Yes ☐ No Any bad reaction? ☐ Yes ☐ No

List all medications you are currently taking (including prescriptions, over-the-counter meds; and herbals):

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

Do you have now, or have you ever had diseases or conductions of: (Please check YES or NO)

Lungs	YES	NO
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Morning Cough	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐

Cardiovascular:	YES	NO
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Phlebitis	☐	☐
Inflammation of vein	☐	☐
Blood clots	☐	☐
Pacemaker	☐	☐

Other Systemic:	YES	NO
Diabetes	☐	☐
Excessive Thirst/hunger	☐	☐
Amputation	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Dialysis	☐	☐
Bladder	☐	☐
Frequency/burning	☐	☐
Gastrointestinal		
Stomach absorptive disorder	☐	☐
Nausea, vomiting, diarrhea	☐	☐
When taking antibiotics	☐	☐
Yeast infection when		
Taking antibiotics	☐	☐
Arthritis/Joint Deformity	☐	☐
Arthralgia	☐	☐
Limited motion	☐	☐
Artificial joint	☐	☐
Convulsions, Epilepsy or Seizures	☐	☐
Fainting	☐	☐

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin:
- Have you ever had skin cancer? ☐ YES ☐ NO
- Has anyone in your family had skin cancer? ☐ YES ☐ NO
- Do you have a history of any specific skin diseases? ☐ YES ☐ NO If yes, _____
- Do you have problems with healing ☐ YES ☐ NO
- Do you develop keloids (scars) after surgery ☐ YES ☐ NO
- Do you bleed easily? ☐ YES ☐ NO
- Do you develop skin rashes in reaction to ☐ Medications ☐ Food ☐ Environment ☐ Bandages ☐ Topical Neosporin ☐ Other _____

Social History:

Do you drink alcohol? ☐ YES ☐ NO If YES _____ drinks per day

Do you use IV drugs? ☐ YES ☐ NO If YES, What? _____ How Often? _____

Do you smoke? ☐ YES ☐ NO If YES, how much: _____

Have you had or have you been exposed to HIV (AIDS)? ☐ YES ☐ NO

Please answer the following questions:

(Women) Are you pregnant? ☐ YES ☐ NO Due Date: _____/_____/_____

What is your occupation? _____ Hobbies? _____

Completed by: ☐ Patient

☐ Medical Assistant _____ (Initials)

_____ Signed by Patient _____/_____/_____ Date

_____ Reviewed by _____/_____/_____ Date