



Please Print

PATIENT INFORMATION

Patient information form including fields for Last Name, First Name, Middle Initial, Mailing Address, City, State, Zip, Street Address, Email Address, Home Phone, Mobile Phone, Work Phone, Patient DOB, Age, Sex, Marital Status, Social Security #, Employer Name and Address, Primary Care Physician, Referring Provider, and How did you hear about our office?

IN CASE OF EMERGENCY

Emergency contact form including fields for Name of Emergency Contact Person, Relationship to Patient, Home Phone, Work or Cell Phone, Mailing Address, City, State, Zip.

RESPONSIBLE PARTY (GUARANTOR) (If patient is spouse, dependant or student)

Responsible party form including fields for Guarantor's Last Name, First Name, Middle Name, Mailing Address, City, State, Zip, Guarantor's DOB, Relationship to Patient, Home Phone, Work or Cell Phone, Guarantor's Social Security #, Guarantor's Employer and Address.

PRIMARY INSURANCE (Please present new insurance card to our office staff)

Primary insurance form including checkboxes for Self-Pay / No Insurance, Patient is the Insured Subscriber, Name of Primary Insurance, Primary Insurance Address, Policy Subscriber's Name, Policy Subscriber's DOB, Policy Subscriber's Phone, Patient's Relation to Subscriber, Policy Subscriber's Social Security #, Subscriber Number, Group Number, Specialist Co-Pay Amount.

SECONDARY INSURANCE (Please present new insurance card to our office staff)

Secondary insurance form including checkboxes for No Secondary Insurance, Patient is the insured Subscriber, Name of Secondary Insurance, Secondary Insurance Address, Policy Subscriber's Name, Policy Subscriber's DOB, Policy Subscriber's Phone, Patient's Relation to Subscriber, Policy Subscriber's Social Security #, Subscriber Number, Group Number, Specialist Co-Pay Amount.

PHARMACY INFORMATION

Pharmacy information form including fields for Pharmacy Name, Pharmacy Location, Pharmacy Phone.

# MEDICAL HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Do you have or have you had any of the following, related to the cause of your visit? (If yes, please check)

|  |   |   |   |
|--|---|---|---|
| <p><b>GENERAL</b></p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Abnormal bleeding</p> <p><input type="checkbox"/> Chills</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Hair loss</p> <p><input type="checkbox"/> Headache</p> <p><input type="checkbox"/> Weight change</p> <p><b>SKIN</b></p> <p><input type="checkbox"/> Acne</p> <p><input type="checkbox"/> Actinic Keratosis</p> <p><input type="checkbox"/> Atopic Dermatitis</p> <p><input type="checkbox"/> Atypical moles</p> <p><input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> Carcinoma (basal/squamous cell)</p> | <p><input type="checkbox"/> Hives</p> <p><input type="checkbox"/> Itching/Rash</p> <p><input type="checkbox"/> Keloid/scarring problems</p> <p><input type="checkbox"/> Melanoma</p> <p><input type="checkbox"/> Mole change</p> <p><input type="checkbox"/> Psoriasis</p> <p><input type="checkbox"/> Sore that won't heal</p> <p><b>MUSCLE/JOINT/BONE PAIN</b></p> <p><input type="checkbox"/> Hands</p> <p><input type="checkbox"/> Knees</p> <p><input type="checkbox"/> Artificial joint/metal implant</p> <p><b>EYES/EARS/NOSE</b></p> <p><input type="checkbox"/> Blurred vision</p> <p><input type="checkbox"/> Light flashes/halos</p> <p><input type="checkbox"/> Earache</p> | <p><input type="checkbox"/> Loss of hearing</p> <p><input type="checkbox"/> Ringing in ears</p> <p><input type="checkbox"/> Nosebleeds</p> <p><input type="checkbox"/> Sinus problems</p> <p><b>CARDIOVASCULAR</b></p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Irregular heartbeat</p> <p><input type="checkbox"/> Low blood pressure</p> <p><input type="checkbox"/> Poor circulation</p> <p><input type="checkbox"/> Rapid heart beat</p> <p><input type="checkbox"/> Swelling of ankles</p> <p><b>GASTROINTESTINAL</b></p> <p><input type="checkbox"/> Appetite loss</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Vomiting</p> | <p><b>MEN only</b></p> <p><input type="checkbox"/> Sore on genitals</p> <p><input type="checkbox"/> Other _____</p> <p><b>WOMEN only</b></p> <p><input type="checkbox"/> Irregular menstrual cycles</p> <p><input type="checkbox"/> Menopause</p> <p><input type="checkbox"/> Nursing</p> <p><input type="checkbox"/> Pregnant</p> <p><input type="checkbox"/> Other _____</p> <p>Date of last period:<br/>_____</p>                                      |
| <p><b>CONDITIONS</b></p> <p><input type="checkbox"/> AIDS</p> <p><input type="checkbox"/> Alcoholism</p> <p><input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Artificial Heart Valve</p> <p><input type="checkbox"/> Atrial Fibrillation</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Autoimmune Disease</p> <p><input type="checkbox"/> Blood/bleeding disorder</p>   | <p><input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> Cancer _____</p> <p><input type="checkbox"/> Cataracts</p> <p><input type="checkbox"/> Chemical dependency</p> <p><input type="checkbox"/> Chicken Pox</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Hay fever</p>   | <p><input type="checkbox"/> Heartburn/Reflux/Ulcers/<br/>Gastritis</p> <p><input type="checkbox"/> Heart Disease</p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> Herpes</p> <p><input type="checkbox"/> High Cholesterol</p> <p><input type="checkbox"/> HIV Positive</p> <p><input type="checkbox"/> Thyroid Disease</p> <p><input type="checkbox"/> Kidney Disease</p> <p><input type="checkbox"/> Liver Disease</p> <p><input type="checkbox"/> Lung Disease</p>   | <p><input type="checkbox"/> Measles</p> <p><input type="checkbox"/> Migraine Headaches</p> <p><input type="checkbox"/> Pacemaker</p> <p><input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> Prostate problem</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Venereal Disease</p> <p><input type="checkbox"/> Other _____</p> |

Have you had any of the following Cosmetic treatments? (If yes, please check)

**INJECTABLES:**

- Botox
- Restylane/Perlane
- Radiesse
- Sculptra
- Cosmoderm/Cosmoplast
- Juvederm
- Artefill
- Sclerotherapy
- Other \_\_\_\_\_

**LASER TREATMENTS:**

- ActiveFX
- Fraxel
- IPL (photo facial)
- Thermage
- Portrait
- Blu-U Light Therapy
- V-Beam (spider veins/redness)
- Photo Dynamic Therapy (PDT)
- Laser Hair Removal
- Laser Tattoo Removal
- Other \_\_\_\_\_

**ESTHETICIAN SERVICES:**

- Vibraderm/Microdermabrasion
- Chemical Peel
- Oxygen Facial
- Aesthetic Facial
- Medical Acne Facial
- Other \_\_\_\_\_
- GloMinerals/Mineral Make-up

Are you interested in learning more about any of the above treatments?  Yes  No

(If yes, please list)

|    |    |    |
|----|----|----|
| 1) | 3) | 5) |
| 2) | 4) | 6) |



Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please list any medications you are currently taking:  None

| Name | Dose | Name | Dose |
|------|------|------|------|
| 1)   |      | 5)   |      |
| 2)   |      | 6)   |      |
| 3)   |      | 7)   |      |
| 4)   |      | 8)   |      |

Please list any herbal supplements and/or vitamins you are currently taking:  None

| Name | Dose | Name | Dose |
|------|------|------|------|
| 1)   |      | 4)   |      |
| 2)   |      | 5)   |      |
| 3)   |      | 6)   |      |

Are you allergic to any medications?  Yes  No (If yes, please list)

|    |    |    |
|----|----|----|
| 1) | 4) | 7) |
| 2) | 5) | 8) |
| 3) | 6) | 9) |

Please list any relatives that have had any of the following: (mother, father, grandmother, grandfather, brother, sister)

- Autoimmune Disease \_\_\_\_\_
- Cancer \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Eczema \_\_\_\_\_
- Elevated Cholesterol \_\_\_\_\_
- Melanoma \_\_\_\_\_
- Psoriasis \_\_\_\_\_
- Seasonal Allergies \_\_\_\_\_
- Skin Cancer \_\_\_\_\_
- Other \_\_\_\_\_

How many do you have of the following? Brothers \_\_\_\_\_ Sisters \_\_\_\_\_ Sons \_\_\_\_\_ Daughters \_\_\_\_\_

- Do you take Coumadin or other blood thinners?  Yes  No
- Do you take Aspirin daily?  Yes  No
- Do you need antibiotics before surgery or dental work?  Yes  No
- Are you allergic to any local anesthetics?  Yes  No
- Are you allergic to latex?  Yes  No
- Are you allergic to polysporin/neosporin?  Yes  No
- Do you smoke?  Yes  No
- Do you drink more than 20 alcoholic beverages/week?  Yes  No
- Do you exercise regularly?  Yes  No

Please list any major surgeries and/or hospitalizations:

|    |       |    |       |
|----|-------|----|-------|
| 1) | Date: | 4) | Date: |
| 2) | Date: | 5) | Date: |
| 3) | Date: | 6) | Date: |

What is your occupation? \_\_\_\_\_

Thank you for taking the time to help us give you the highest quality care.



## SIGNATURE PAGE

### **Release of Medical Information**

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions.

### **Financial Policy – All Patients, Including Medicare**

Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments will be collected. The patient is responsible for any/all charges not paid for by their insurance company. I agree, either as an agent or as the patient, that I am obligated to pay any/all fees for the exam that may not be covered or authorized by my insurance carrier.

### **Financial Policy – Medicare Patients Only**

I authorize any holder of medical records or other information about me to release to the Social Security Administration and Center for Medicare Services, or its intermediaries or carrier, any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. This authorization is valid until revoked in writing.

### **Cancellation Policy – Medical**

If you must cancel or reschedule a Medical appointment, please do so at least 24 hours before the scheduled appointment time. Two missed appointments without 24 hours notice will result in a \$50.00 charge for general medical visits and a \$100.00 charge for surgical visits using the credit card on file. Please remember our policies are created to allow for effective scheduling and to ensure all patients wishing to receive services may be accommodated. Please help us to better serve you by notifying us as soon as possible if you must change or cancel your appointment.

### **Cancellation Policy – Cosmetic**

When scheduling cosmetic services, we require credit card information to be kept on file to reserve the appointment. Cosmetic appointments must be canceled with a minimum of 48 hours notice. If our office has not received notice to cancel your appointment within the required time frame, your credit card will be charged 50% of the cost of your cosmetic procedure(s). With respect to prepaid cosmetic treatment packages, we also require a minimum of 48 hours to cancel an appointment. If you do not cancel your appointment within the required time frame, you will be billed a \$100 inconvenience charge. Cosmetic procedures are not covered by insurance and are performed on a cash basis only.

### **Privacy Practices (HIPAA)**

- **Receipt of Privacy Practices:** By signing below, I acknowledge that I have received a copy of the Torrey Pines Dermatology Privacy Practices.
- **Contact Information:** By signing below, I authorize Torrey Pines Dermatology to leave a message only asking me to return the call. If I wish a detailed message to be left, I will give permission to a staff member.

If you are over 18 years old, do we have permission to speak to your parents about your care?     YES     NO

Please list any persons to whom your protected health information *can* be disclosed (e.g. spouse, parent, etc.):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

*My signature below acknowledges that I have read, understood, and agreed to all of the above Torrey Pines Dermatology Policies.*

**Please Print Patient's Name:** \_\_\_\_\_

**Patient/Responsible Party Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_