



**SIGNATURE PAGE for** \_\_\_\_\_  
(patient name)

**Release of Medical Information**

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

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**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, co-insurance and deductibles will be collected. All medical procedures performed have separate fees in addition to office visit fee. Our office **does not** accept Cal-Optima/Medical /Medicaid, any HMO insurance, any worker’s compensation cases, some PPO insurance plans, and may not accept other plans. Patients are responsible to check our participation with their plan before their visit. The patient is responsible for any and all charges not paid for by their insurance company. If you must cancel or reschedule an appointment, please do so at least 24 hours before the scheduled appointment time. A charge of \$50 may be applied to patients who miss their appointment or do not notify the office of a cancellation 24 hours in advance.

I have read and understand the financial policy statement. I agree to make in-full prompt payment when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered. Further, I authorize payment directly to The Dermatology Center at Ladera for medical insurance benefits payable to me under the terms of my policy. This authorization is valid until revoked in writing. ***The SIGNER must complete THEIR OWN information here:***

Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signer’s Address: \_\_\_\_\_ Signer’s Telephone: \_\_\_\_\_

Signer’s Date of Birth: \_\_\_\_\_ Signer’s Social Security Number: \_\_\_\_\_

**Financial Policy – Medicare Patients Only**

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a 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.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Privacy Practices (HIPAA)**

Notice of Privacy Practices

- A copy of this notice is available to you. Please ask the reception staff if you would like one. By signing below, I acknowledge that I have been offered a copy of our Notice of Privacy Practices.

Contact Information

- By signing below, I authorize The Dermatology Center at Ladera to leave a detailed message in reference to any items that assist the practice in carrying out healthcare operations. If you **do not** wish to be contacted at a specific location, please indicate below:

**Home Phone: Do not contact me here | Work Phone: Do not contact me here**  
**Mobile Phone: Do not contact me here | Email: Do not contact me here**

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

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

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

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**MEDICAL QUESTIONNAIRE**

Patient Name: \_\_\_\_\_

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

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

Do you have or have had any of the following? (if yes, please check)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Acne   | <input type="checkbox"/> Diabetes                              | <input type="checkbox"/> Psoriasis   |
| <input type="checkbox"/> Actinic Keratosis                                      | <input type="checkbox"/> Down's Syndrome                       | <input type="checkbox"/> Reactions to local anesthesia                     |
| <input type="checkbox"/> Artificial heart valve                                 | <input type="checkbox"/> Heartburn/Ulcers/<br>Gastritis/Reflux | <input type="checkbox"/> Seasonal allergies/asthma                         |
| <input type="checkbox"/> Artificial joints or metal<br>implant                  | <input type="checkbox"/> Heart disease                         | <input type="checkbox"/> Seizures  |
| <input type="checkbox"/> Atopic Dermatitis                                      | <input type="checkbox"/> Hepatitis                             | <input type="checkbox"/> Stroke  |
| <input type="checkbox"/> Atrial Fibrillation                                    | <input type="checkbox"/> High blood pressure                   | <input type="checkbox"/> Skin Cancer (basal or<br>squamous cell carcinoma) |
| <input type="checkbox"/> Atypical moles   | <input type="checkbox"/> HIV                                   | <input type="checkbox"/> Cancer, other                                     |
| <input type="checkbox"/> Autoimmune disease<br>(lupus, rheumatoid<br>arthritis) | <input type="checkbox"/> Keloids or scarring<br>problems       | <input type="checkbox"/> Please list:                                      |
| <input type="checkbox"/> Bleeding disorder                                      | <input type="checkbox"/> Kidney disease                        |  |
| <input type="checkbox"/> Blood clots  | <input type="checkbox"/> Liver disease or hepatitis            | <input type="checkbox"/> Thyroid trouble                                   |
| <input type="checkbox"/> Chronic<br>Fatigue/Fibromyalgia                        | <input type="checkbox"/> Lung disease                          | <input type="checkbox"/> Other conditions                                  |
| <input type="checkbox"/> Cold sores/herpes                                      | <input type="checkbox"/> Melanoma                              | <input type="checkbox"/> Please list:                                      |
| <input type="checkbox"/> Depression   | <input type="checkbox"/> Migraines                             |  |
|   | <input type="checkbox"/> Multiple Sclerosis                    |  |
|   | <input type="checkbox"/> Pacemaker                             |  |

Please list any medications, herbal supplements and/or vitamins you are currently taking:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to any medications?  Yes  No (if yes, please list medication and reaction)

Medication: \_\_\_\_\_ Reaction: \_\_\_\_\_ Medication: \_\_\_\_\_ Reaction: \_\_\_\_\_

Medication: \_\_\_\_\_ Reaction: \_\_\_\_\_ Medication: \_\_\_\_\_ Reaction: \_\_\_\_\_

Please list major surgeries:

_____	Date: _____	_____	Date: _____
_____	Date: _____	_____	Date: _____
_____	Date: _____	_____	Date: _____

Please list major hospitalizations:

_____	Date: _____	_____	Date: _____
_____	Date: _____	_____	Date: _____

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

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

- |  |  |
|--|--|
| <input type="checkbox"/> Skin Cancer: _____          | <input type="checkbox"/> Seasonal Allergies: _____ |
| <input type="checkbox"/> Eczema: _____               | <input type="checkbox"/> Psoriasis: _____          |
| <input type="checkbox"/> Melanoma: _____             | <input type="checkbox"/> Autoimmune disease: _____ |
| <input type="checkbox"/> Diabetes: _____             | <input type="checkbox"/> Cancer: _____             |
| <input type="checkbox"/> Elevated Cholesterol: _____ | <input type="checkbox"/> Other: _____              |

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

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Do you take Coumadin or other blood thinners?          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you take aspirin daily?                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you need antibiotics before surgery or dental work? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you pregnant or nursing?                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you allergic to any local anesthetic?              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you exercise?                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you drink alcoholic beverages?                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If so, how much (number of beverages/week)?            | _____                        |                             |
| What is your occupation?                               | _____                        |                             |

**Tobacco Use** (please check one category)

- Never a smoker.
- Former smoker. If Yes, how long has it been since you last smoked? (please check one)
- <1 month  1-3 months  3-6 months  6-12 months  1-5 years  5-10 years  >10 years
- Current smoker. If Yes:
- How often do you smoke Cigarettes? (please check one)
- every day  some days, but not every day
- How many cigarettes a day do you smoke? (please check one)
- 5 or less  6-10  11-20  21-30  31 or more
- How soon after you wake up do you smoke your first cigarette? (please check one)
- within 5 min  6-30 min  31-60 min  after 60 min
- Are you interested in quitting? (please check one)
- Ready to quit  Thinking about quitting  Not ready to quit

**Have you recently had any of the following?** (Please check all that apply)

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Weight change        | <input type="checkbox"/> Neck stiffness      | <input type="checkbox"/> Nausea                | <input type="checkbox"/> Change in hair pattern     |
| <input type="checkbox"/> Fever                | <input type="checkbox"/> Enlarged glands     | <input type="checkbox"/> Vomiting              | <input type="checkbox"/> Easy bruising              |
| <input type="checkbox"/> Chills               | <input type="checkbox"/> Sore throat         | <input type="checkbox"/> Diarrhea              | <input type="checkbox"/> Abnormal bleeding          |
| <input type="checkbox"/> Fatigue              | <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Seizures                   |
| <input type="checkbox"/> Headache             | <input type="checkbox"/> Palpitations        | <input type="checkbox"/> Blood in urine        | <input type="checkbox"/> Irregular menstrual cycles |
| <input type="checkbox"/> Vision changes       | <input type="checkbox"/> Leg swelling        | <input type="checkbox"/> Joint pain            | <input type="checkbox"/> Depression                 |
| <input type="checkbox"/> Ringing in ears      | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Muscle aches          | <input type="checkbox"/> Nervousness                |
| <input type="checkbox"/> Recurrent nosebleeds | <input type="checkbox"/> Cough               | <input type="checkbox"/> Heat/Cold intolerance |   |



**PATIENT INFORMATION**

Name: \_\_\_\_\_  
*Last First M.I.*

Address: \_\_\_\_\_  
*Street City State Zip*

Telephone: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
*Home Mobile Work ext*

Primary Care Physician: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex:  M  F Social Security Number: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Legally Separated

Patient Race:  White  Hispanic  Asian  Black or African American  American Indian or Alaska Native  Native Hawaiian  
 Other Pacific Islander  Other Race

Ethnicity:  Hispanic  Non-Hispanic Preferred Language:  English  Spanish  Other: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Home Telephone: \_\_\_\_\_ Emergency Contact Work Telephone: \_\_\_\_\_

Patient Email Address: \_\_\_\_\_

Pharmacy Name & Location: \_\_\_\_\_ Pharmacy telephone: \_\_\_\_\_

EMPLOYMENT STATUS:  Full Time  Part-Time  Self-Employed  Retired  Not employed  Student

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
*Street City State Zip*

**INSURANCE INFORMATION**

Please check one:

Self Pay (no insurance)  Patient IS the policy holder  Patient IS NOT the policy holder (fill out below)

If the above named patient is not the primary policy holder, please fill out the following:

**INSURED INFORMATION**

Name: \_\_\_\_\_  
*Last First M.I.*

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Sex:  M  F

Address: \_\_\_\_\_  
*Street City State Zip*

Telephone: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
*Home Mobile Work ext*

Patient's Relationship to insured (i.e. child, spouse, etc.): \_\_\_\_\_

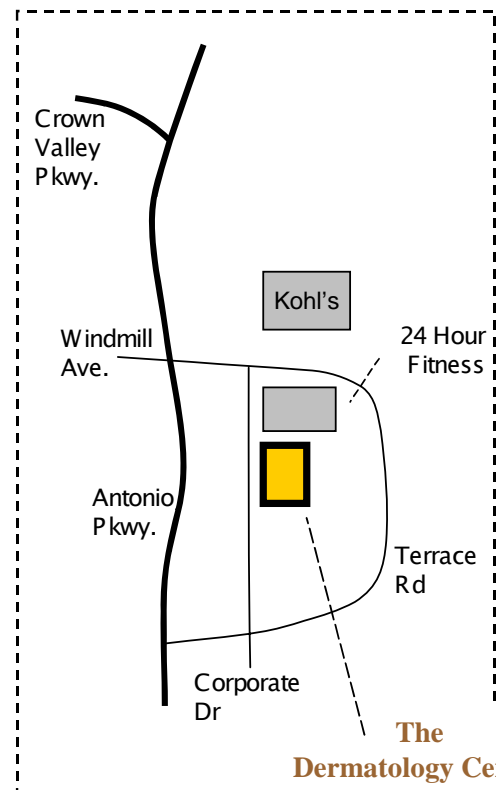
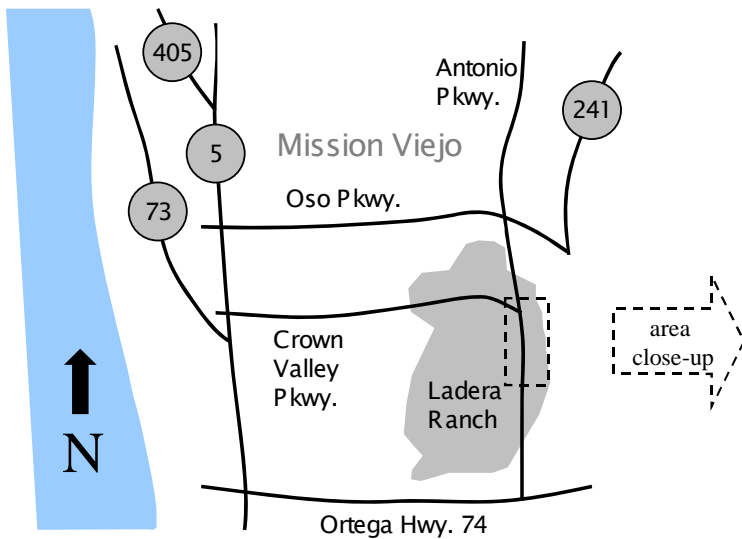
**How did you find us?**

Physician (Name : \_\_\_\_\_)  Family or Friend (Name : \_\_\_\_\_)  
 Yellow Pages  Insurance Book  Internet  Newspaper Ad  Other: \_\_\_\_\_



## Driving Directions from Interstate 5:

Exit Crown Valley Parkway away from the ocean (east)  
Right on Antonio Parkway (south)  
Left on Windmill Ave (east)  
Right on Corporate Drive (south)  
2<sup>nd</sup> Building on the left is 600 Corporate Drive  
600 Corporate Drive, Suite 240



**The  
Dermatology Center  
At Ladera  
600 Corporate Dr.  
Suite 240  
(949) 364-8411**