PATIENT REGISTRATION INFORMATION Date_____
Initial_____

Please complete both sides of this form.

PATIENT'S PERSONAL INFORMATION

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Male ☐Female

Name: _____ _____ _____ ( ) _____
last name *first name* *middle init.* ***Preferred Phone***

Street Address: _____ Apt.# _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ Apt.# _____ City: _____ State: _____ Zip: _____

Alternate Phone: ( ) _____ Wk. phone: ( ) _____ E-mail: _____

Date of Birth: _____/_____/_____ Age: _____

Ethnicity (circle one): Hispanic/Latino NOT Hispanic/Latino Unknown

Race (circle one): White American Indian or Alaskan Native Asian Black or African American
Native Hawaiian or Other Pacific Islander Other Race

Language (select one): English Spanish Other (fill in): _____

Employer: _____ Occupation: _____

Spouse's Name: _____ _____ Date of Birth: _____/_____/_____
last name *first name*

Spouse's Employer's Name: _____ Phone No. ( ) _____

RESPONSIBLE PARTY INFORMATION

☐Info same as above

Responsible Party: _____ Date of Birth: _____/_____/_____

Relationship to Patient: SELF SPOUSE OTHER _____

Responsible Party's Home Phone: ( ) _____ Work Phone: ( ) _____

Street Address: _____ Apt.# _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ Apt.# _____ City: _____ State: _____ Zip: _____

Employer's Name: _____ Phone No. ( ) _____

EMERGENCY CONTACT

Name of person not living with you: _____

Relationship to you: _____ Address: _____

City: _____ State: _____ Zip: _____ Home Phone #: ( )_____

Wk. Phone #: ( )_____ Cell. Phone #: ( )_____

OTHER INFORMATION

Name of Physician/Friend/Directory who referred you: _____

Primary Care Physician: _____ Phone #: ( )_____

PATIENT'S INSURANCE INFORMATION

(Please present insurance cards and picture ID at check-in so that copies can be made)

Name of Insured: _____ Does your insurance require a referral? _____

Primary Insurance: _____ Effective Date: _____
Your Relationship to insured: SELF SPOUSE OTHER My Insurance is: ☐HMO ☐PPO ☐EPO ☐Other

Secondary Insurance: _____ Effective Date: _____

Your Relationship to insured: SELF SPOUSE OTHER My Insurance is: ☐HMO ☐PPO ☐EPO ☐Other

Financial Responsibility

ASSIGNMENT OF BENEFITS

I assign payment of benefits for medical services be made on my behalf to Dermatologist Medical Group of North County, Inc (a Medical Corporation), for services rendered. I authorize the release of my personal medical information to the Health Care Financing Administration, its agents, or agents of my health insurance as needed to determine benefits payable for related services. This assignment of benefits will remain in effect for future services relative to this or any other health insurance I may have.

FINANCIAL AGREEMENT

If DMGNC is contracted with your health insurance, we will bill your insurance for you. However, the patient is required to understand the benefits and restrictions of their individual health insurance. If your health insurance requires a prior authorization for medical care, the patient is responsible for obtaining this, and providing proof of authorization before scheduling an appointment. It is your responsibility to notify us if there are any changes in your health insurance, primary care physician, address, employment, etc. Co-pays and deductibles will be collected prior to your visit with the physician or physician assistant.

I understand that I am financially responsible for all charges for services provided by Dermatologist Medical Group of North County, Inc., (DMGNC) whether or not they are covered or paid by my health insurance. By signing this form you agree that you are responsible for any charges provided by Dermatologist Medical Group of North County, Inc. and its Providers if they are not covered by your health insurance for any reason. In addition, you are responsible for any deductible or co-share determined by your health insurance. Further, you agree that in the event of default you will pay all costs of collection, and reasonable attorney's fees. *A copy of this agreement shall be as valid as the original.*

_____	_____	_____
Patient Name	**Date**	**Patient Signature or Guardian Responsible Party**

General Appointment Information

COSMETIC PROCEDURES

Cosmetic procedures are cash visits only and cannot be billed to insurance. These procedures include but are not limited to: Botox, Juvéderm, Restylane, Hair Removal, Facial Veins, Spider Veins, and Skin Tags or Benign Growths. Credit Card information is required to hold this appointment time for you.

DISABILITY FORMS

Because disability and other related forms have become more extensive and time consuming to fill out, there is now a $15.00 charge for completing them. This is not covered by the insurance and is therefore the patient's responsibility.

MISSED and LATE APPOINTMENTS

Your appointment time is reserved for you. We will send an automated phone call reminder for your scheduled appointment. If you are scheduled for a procedure you may also receive a call from one of our staff.

If you need to cancel your office visit, we require a 24 hour notice. If you need to cancel a cosmetic procedure or surgery, we require a 48 hour notice. This will allow us to contact and schedule a patient who is waiting for an appointment time. If you miss a scheduled appointment and did not cancel within the time frame required, you will be required to make a $50.00 deposit when you schedule your next appointment.

If you are more than 15 minutes late for your appointment we will make an attempt to accommodate you during that session. However, this may involve seeing another practitioner, waiting to be seen at the end of the session or rescheduling for another day. When appointments are missed or canceled at the last minute another patient is deprived of the opportunity to see the physician during that time.

Name: _____

D.O.B: _____

☐ Entered

DERMATOLOGIST MEDICAL GROUP OF NORTH COUNTY, INC.

History and Intake Form

Past Medical History: (Please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension (high blood pressure)
HIV/AIDS
Hypercholesterolemia (high cholesterol)
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
None
Other _____

Past Surgical History: (Please circle all that apply)

Appendix Removed
Bladder Removed
Breast Biopsy: (Right, Left, Bilateral)
Breast Implants
Breast Lumpectomy: (Right, Left, Bilateral)
Breast Mastectomy: (Right, Left, Bilateral)
Breast Reduction
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Heart: Biological Valve Replacement
Heart: Coronary Artery Bypass
Heart: Mechanical Valve Replacement
Heart: Pacemaker
Heart: PTCA
Heart: Transplant
Joint Replacement: Knee (Right, Left, Bilateral)
Joint Replacement: Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney: Biopsy
Kidney: Removed (Right, Left)
Kidney: Stone Removal
Kidney: Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Ovarian Cancer
Ovaries Removed: Ovarian Cyst
Prostate: Prostate Biopsy
Prostate Removed: Prostate Cancer
Prostate (Prostatectomy): TURP
Skin: Basal Cell Cancer Surgery
Skin: Skin Biopsy
Skin: Melanoma Surgery
Skin: Squamous Cell Carcinoma Surgery
Spleen Removed
Testicles Removed: (Right, Left, Bilateral)
Uterus (Hysterectomy): Fibroids
Uterus (Hysterectomy): Uterine Cancer
None
Other _____

Skin Disease History: (Please circle all that apply)

Acne
Actinic Keratoses
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Rosacea
Squamous Cell Skin Cancer
None
Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Any other family history: _____

Allergies: (Please enter all allergies)

_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:
- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Alcohol Use:
- Alcohol: none
- Alcohol: less than 1 drink a day
- Alcohol: 1-2 drinks a day
- Alcohol: 3 or more drinks a day

Vitals:
- Height: _____
- Weight: _____

Other:
Do you have an Advanced Directive? Yes No
Do you have a medical Power of Attorney? Yes No
If yes, is it currently in effect? Yes No
If yes, who? _____

How did you hear about us? (Please circle or fill in)

Referred by a physician. Dr. _____

Community Event Internet Friend Insurance Family

DERMATOLOGIST MEDICAL GROUP OF NORTH COUNTY, INC.

Zee Durrani, Privacy Officer 760-758-5340

I hereby acknowledge that I reviewed a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

_____	_____	_____	_____
Signature	*Date*	*Print Name*	*Telephone*

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, parents or others to call and request the results of tests and procedures. Under the requirements for HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your test results released to family members you must sign this form. Signing this form will only give consent to release appointment information, test, and procedure results to the family members indicated below. This consent form will not allow Dermatologist Medical Group of North County, Inc. to release any other information to these family members.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Dermatologist Medical Group of North County, Inc. to release medical information, test and procedure results to the following individuals:

_____	_____	(_____)_____	___/___/___
Name	*Relation to Patient*	*Telephone*	*Date of Birth*
_____	_____	(_____)_____	___/___/___
Name	*Relation to Patient*	*Telephone*	*Date of Birth*

_____

Signature of Patient, or Personal Representative ***Date***

_____

If Personal Representative, Relationship to Patient

Patient Medication List

Pharmacy Information: (Please provide as much information as possible)
Pharmacy Name: _____
City: _____ Zip Code: _____
Phone Number: _____

Please list any Medications you are taking including any over the counter vitamins and supplements:

Medication Name	**Strength** (ex. *50mg)*	**Frequency** *(once a day)*	**Route of administration** (ex. orally)