

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.



DERMATOLOGIST MEDICAL GROUP OF NORTH COUNTY, INC.

History and Intake Form

Past Medical History: (Please circle all that apply)

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

Past Surgical History: (Please circle all that apply)

Breast Implants	Heart: Transplant	Skin: Basal Cell Cancer Surgery
Heart: Biological Valve Replacement	Joint Replacement: Knee (Right, Left, Bilateral)	Skin: Melanoma Surgery
Heart: Coronary Artery Bypass	Joint Replacement: Hip (Right, Left, Bilateral)	Skin: Squamous Cell Carcinoma Surgery
Heart: Mechanical Valve Replacement	Joint Replacement within last 2 years	Other:
Heart: Pacemaker	Kidney: Transplant	

Skin Disease History: (Please circle all that apply)

Acne	Melanoma
Actinic Keratosis	Poison Ivy
Basal Cell Carcinoma	Precancerous moles
Blistering sunburns	Psoriasis
Dry Skin	Rosacea
Eczema	Squamous cell carcinoma
Flaking or itchy scalp	NONE
Hay fever/ allergies	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:

Primary Care Provider (First, last name):

If you were referred by a physician: _____



DERMATOLOGIST MEDICAL GROUP OF NORTH COUNTY, INC.
Zee Durrani, Privacy Officer 760-758-5340

I hereby acknowledge that I reviewed a copy of Dermatologist Medical Group'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:

_____	_____	(____)_____	____/____/____
<i>Name</i>	<i>Relation to Patient</i>	<i>Telephone</i>	<i>Date of Birth</i>

_____	_____	(____)_____	____/____/____
<i>Name</i>	<i>Relation to Patient</i>	<i>Telephone</i>	<i>Date of Birth</i>

Signature of Patient, or Personal Representative

Date

If Personal Representative, Relationship to Patient



Patient Name: _____ Date: _____

Were you referred by a Physician?

Referring Physician name: _____

Tobacco use? (circle answer below)	Have you had the Flu shot? (circle answer below)
Never used	Yes; date of last:
Former User	No, for personal reasons
Current user	No, I'm allergic

For Patients 65 years or older:

Have you had a pneumonia vaccine?	Do you have an advanced directive?	Yes	No
Yes; approximate date given:	Do you have a medical power of Attorney?	Yes	No
No, for personal reasons	If yes, is it currently in effect?	Yes	No
No, I'm allergic	If yes, who? (document name below)		
	Name:		

MIPS 2020