ADVANCED DERMATOLOGY CARE
OF SOUTHERN CALIFORNIA

PATIENT INFORMATION (Circle): New Patient Name Change Address Change Insurance Change

Name (Last, First, MI) _____ Date: _____

Social Security #_____ Date of Birth: _____ Age: _____ Male ☐ Female ☐

Mailing Address: _____
Street City State Zip

Email Address: _____

Marital Status: ___Single ___Married ___Divorced ____Domestic Partnership ____Widowed ___ Separated

Employer: _____ Occupation: _____

Home Phone: _____ Cell Phone:_____

Work Phone: _____

Do we have permission to leave a voice message on your home, cell or work telephone? YES ☐ NO ☐

Do we havepermission to release medical information to your spouse, partner or others? YES ☐ NO ☐

Emergency Contact: _____ ___Phone:#_____

REFERRING PHYSICIAN:_____ Phone Number: _____

PRIMARY PHYSICIAN: _____Phone Number: _____

REFERRED BY: _____

RESPONSIBLE PARTY (if different from patient) ___PARENT ___SPOUSE OTHER _____
Name: _____ D.O.B____/____/____Home Phone: _____

Mailing Address: _____

PHARMACY INSURANCE COVERAGE:
Pharmacy Co. Name_____

ID_____BIN_____ PCN_____

INSURANCE COVERAGE- PRIMARY
Insurance Co. Name_____ Policy Type: PPO ☐ EPO ☐ POS ☐ HMO ☐

Policy #: _____ Group #: _____

Name of Policy Holder (Insured): _____ D.O.B____/____/____

SS#_____ If patient is child, check relationship: Mother ☐ Father ☐ Other: _____

INSURANCE COVERAGE- SECONDARY
Insurance Co. Name_____ Policy Type: PPO ☐ EPO ☐ POS ☐ HMO ☐

Policy #: _____ Group #:_____

Name of Policy Holder (Insured):_____ D.O.B____/____/____

FINANCIAL POLICY

Name (Last, First, MI) _____Date of Birth: _____

You have the right and responsibility of knowing the cost of your medical treatment. Since we are responsible for your well-being, we would like to give you some information regarding insurance coverage. There are many different insurance companies and within each company, many different plans, and within each plan, there are several different levels of coverage. Since there is such variety, it would be wise for you to check your specific policy so that you will be aware of what coverage you actually have. After all, you are responsible for knowing your coverage. It has been our experience that people are often surprised when they learn exactly what their coverage really is. Sometimes certain services are not covered, and payment is denied by the insurance company. We do not and cannot determine our fee schedule based on the abundant number of insurance companies and their varying levels of coverage. Furthermore, we do not want to be involved in disputes between you and your insurance company. By continuing as our patient, you agree to pay our fees even though your insurance company may not cover all costs completely.

You are responsible for paying your annual deductible, co-payment, co-Insurance and charges for any non-covered and cosmetic services. After your insurance processes your claim, your balance is due in full within 30 days. Additionally, if your insurance company requires authorization and you do not have one at the time of service, you are responsible for the charges in full. If your deductible has not been met and you have co-insurance, we collect a portion of your deductible and co-insurance at the time of visit. If you do not have insurance, we will ask for full payment at the time of service.

If you have not satisfied your deductible, a portion of your deductible will be collected at the time of service.

New Patient Office Visit	**$100**
Established Office Visit	**$50**
Biopsy & Pathology	**$150**
Excision	**$350**
Mohs Surgery	**$750**

Please have the correct and current insurance information available at the time of your visit; you will need to furnish it promptly or provide payment in full. If your insurance information is subsequently provided and results in payment from your insurance company, your payment will be refunded. If your insurance company requests any additional forms or information from you in order to process our claim, we expect that you will comply within 7days. We also file your claim with your secondary insurance; however, in the event that the secondary does not pay within 60 days, you will be billed. We appreciate your cooperation and understanding in this matter.

_____Please be advised that you MIGHT receive a separate bill from a Dermatopathologist for second opinions of your biopsy specimen(s).

_____A $35 processing fee is added to all checks returned due to insufficient funds, closed accounts or if your check does not clear for any reason.

_____ If you are not able to keep your appointment, please give us a 24 notice for regular appointments and 72 hours notice for MOHS surgeries. Cancellation fee may apply if the appointment is cancelled within less than 24 hours notice or if you do not show up for your scheduled appointment.

Cancellation fees:

Follow up appointments	**$25**
Surgical/ Cosmetic appointments	**$50**
MOHS surgery	**$100**

_____I have read the above letter and agree that the payment of these fees is my responsibility. I also authorize the release of any medical records or other information to process my health claim. This office is required to keep your signature on file which authorizes us to file claims to Medicare and other payer for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

_____Signature below is also acknowledgement that you have received a copy of our **HIPPA Notice Privacy.**

_____ _____

Patient Name (Print) Patient Signature (or guardian, if minor)

_____ _____

Guardian Name (Print) Date

ADVANCED DERMATOLOGY CARE OF SOUTHERN CALIFORNIA

Name (Last, First, MI) _____ ***Datef of Birth:*** _____

Past Medical History:

__ None

__ Anxiety
__ Arthritis
__ Asthma
__ AFib (Irregular Heartbeat)
__ Bone Marrow Transplant
__ BPH
__ Breast Cancer
__ Colon Cancer
__ COPD
__ Coronary Artery Disease
__ Depression
__ Diabetes
__ End Stage Renal Disease
__ GERD
__ Other_____

__ Hearing Loss
__ Hepatitis
__ Hypertension
__ HIV / AIDS
__ Hypercholesterolemia
__ Hyperthyroidism
__ Hypothyroidism
__ Leukemia
__ Lung Cancer
__ Lymphoma
__ Prostate Cancer
__ Radiation Treatment
__ Seizures
__ Stroke

Past Surgery:

__ None

__ Appendix, Appendectomy
__ Bladder (Cystectomy)
__ Breast Biopsy
Both__Right__Left
__ Breast Lumpectomy
Both__Right__Left
__ Breast Mastectomy
Both__Right__Left
__ Colon Cancer Resection
__ Colon Diverticulitis
__ Colon Inflammatory Bowel Disease
__ Colon: Colostomy
__ Gallbladder Cholecystectomy
__ Heart : Biological Valve Replacement
__ Heart : Coronary Artery Bypass Surgery
__ Heart : Heart Transplant
__ Heart : Mechanical Valve Replacement
__ Heart : PTCA
__ Joint Replacement : Hip
Both__Right__Left
__ Joint Replacement : Knee
__ Both__Right__Left
__ Kidney Biopsy
__ Other_____

__ Kidney Stone Removal
__ Kidney Transplant
__ Kidney Nephrectomy
__ Liver: Hepatectomy
__ Liver Transplant
__ Liver Shunt
__ Ovaries Endometriosis
__ Ovarian Cancer
__ Ovarian Cyst
__ Ovaries: Tubal Ligation
__ Pancreas: Pancreatectomy
__ Prostate Biopsy
__ Prostate : Prostatectomy
__ Prostate : TURP
__ Rectum: APR
__ Rectum: Low Anterior Resection
__ Skin : Basal Cell Carcinoma
__ Skin : Melanoma
__ Skin : Skin Biopsy
__ Skin : Squamous Cell Carcinoma
__ Spleen (Splenectomy)
__ Testicles (Orchiectomy)
__ Uterus : Fibroids
__ Uterus : Uterine Cancer
Uterus : Cervical Cancer

Skin Conditions:

__ None

__ Acne
__ Actinic Keratoses
__ Asthma
__ Basal Cell Skin Cancer
__ Blistering Sunburns
__ Dry Skin
__ Eczema
__ Other_____

__ Flaking or Itchy Scalp
__ Hay Fever/Allergies
__ Melanoma
__ Poison Ivy
__ Precancerous Moles
__ Psoriasis
__ Squamous cell skin cancer

Do you wear Sunscreen? __Yes __No
If yes, what SPF?_____
Do you tan in a tanning salon? __Yes __No

Family History

Do you have a family history of Melanoma?
__Yes __No
If yes, which relative?_____

Medications : *(List all your current Medication)*

__ None

*1.*_____*Dose:*_____
*2.*_____*Dose:*_____
*3.*_____*Dose:*_____
*4.*_____*Dose:*_____
*5.*_____*Dose:*_____
*6.*_____*Dose:*_____

Do you give us Consent to Import Rx History?
__Yes __No

Allergies : *(Please enter all your current allergies)*

__ None

1. _____ 2. _____
3. _____ 4. _____

Smoking Status:

__Current every day smoker
__Current some day smoker
__Former smoker
__Never smoker

Alcohol Use:

__None
__Less than 1 drink per day
__1-2 drinks per day
__More than 3 drinks per day

Do we have permission to leave a message on your voice mail?
__Yes __No
Do we have permission to release medical information to your spouse, parents or others? __Yes __No
Name:_____

ADVANCED DERMATOLOGY CARE OF SOUTHERN CALIFORNIA

Name (Last, First, MI) _____ ***Datef of Birth:*** _____

REFERRING PHYSICIAN:_____ Phone Number:_____

PRIMARY PHYSICIAN:_____ Phone Number:_____

PHARMACY NAME:_____ Phone Number:_____

ADDRESS:_____ Phone Number:_____

Reason for your visit:

1. _____ 2._____

3. _____ 4. _____

Mark all that applies:

__ **None**

__ problems with bleeding
__ problems with healing
__ problems with scarring (hypertrophic or keloid)
__ rash
__ immunosuppression
__ hay fever
__ chest pain
__ fever or chills
__ night sweats
__ unintentional weight loss
__ thyroid problems
__ sore throat
__ blurry vision

__ abdominal pain
__ bloody stool
__ bloody urine
__ joint aches
__ muscle weakness
__ neck stiffness
__ headaches
__ seizures
__ cough
__ shortness of breath
__ wheezing
__ anxiety
__ depression

__allergy to adhesive
__allergy to lidocaine
__allergy to topical antibiotic ointments
__artificial heart valve
__artificial joints within past two years
__blood thinners
__defibrillator
__MRSA
__pacemaker
__premedication prior to procedures
__rapid heart beat with epinephrine
__pregnancy or planning a pregnancy

Advance Care

Which statement best reflects your wishes on advanced care recommendations?

__ Full Code (Full Cardiopulmonary Resuscitation)
I want full cardiopulmonary resuscitation efforts to be made.

__ Do Not Intubate:
I do not wish to have a breathing tube, even if it is necessary to save my life.

__ Do Not Resuscitate:
If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if its necessary to save my life.

__ Do you have living will?

__ Do you have a health care proxy in the event you are unable to make your own medical decisions?

Name and contact informatioin for Health Care Proxy?_____

Vaccination Status

__Influenza (flu) Date:_____

__Pneumonia Date:_____

__Zoster (Shingle) Date:_____