Comprehensive Dermatology Group
PEDIATRIC & ADULT SPECIALISTS

# ADULT PATIENT INFORMATION

781 Garden View Ct., Suite 201, Encinitas, CA 92024
Phone 760 634 3376 Fax 760 634 7955

**PLEASE PRINT AND COMPLETE BOTH SIDES**

**Date:** _____

**Patient Name:** ____ _____
Title Last First MI

**Nickname:** _____ **Spouse Name:** _____

**DOB:** _____/_____/_____ **Age:** _____ **Gender:** Male Female

**Transgender:** Male/man (FTM) Female/woman (MTF) Nonbinary Prefer not to say/other

**Home Address:** _____
Street City State Zip

**Mailing Address:** _____
(If different from above) Street City State Zip

**Phone:** (_____) _____ (_____) _____ (____) _____
Home Cell Work

**Employer's Name:** _____ **Occupation:** _____

**Best place to leave message, including confidential information:** (____) _____

**Email:** _____

## INSURANCE INFORMATION

**Primary Insurance Co:** _____

**Name of Insured:** _____

**Your relationship to insured:** **Self** **Spouse** **Parent**

**Member ID #:** _____ _____ **Group #:** _____

**Secondary Insurance Co:** _____

**Name of Insured:** _____

**Your relationship to insured:** **Self** **Spouse** **Parent**

**Member ID #:** _____ **Group #:** _____

**PLEASE COMPLETE FRONT AND BACK**

Modified: 01/06/2012

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## EMERGENCY CONTACT INFORMATION

Name: _____

Relationship to patient: _____

Phone: (_____)_____ (_____)_____ (_____)_____
Home Cell Work

## REFERRAL INFORMATION

Name of physician or friend that referred you: _____

Referring physician phone number: (_____)_____

Primary Care Physician: _____

Primary Care phone number: (_____)_____

## PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy Address: _____

## FINANCIAL AGREEMENT

We are committed to providing you with the best possible care, and will help you receive your maximum allowable insurance benefits. However, we need your assistance and your understanding of our payment policy. Your insurance contract is between you, your employer and the insurance company. **Not all services are covered by all contracts.** We participate and accept assignment from most major payers, which means covered charges, will be paid directly to us. As a courtesy to you, we will file a claim with your insurance carrier on your behalf. Any remaining balance will be billed to you once we have received payment from your insurance carrier. If we do not participate in your insurance plan, you may still choose to be seen in our practice as a "SELF PAY" patient. Our physicians offer a discounted "SELF PAY" rate that is due at time of service.

Your Signature: _____ Date: _____

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# PATIENT MEDICAL HISTORY FORM

**Date:** _____

**Name:** _____ **DOB:** _____

**Reason for Visit:** _____

_____

**Allergies:** _____

**Current Medications** (include prescriptions, over-the counter, vitamins, herbals):

| Medication | Dose | Frequency | When started |
|---|---|---|---|
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**Major Medical Illnesses/Surgeries:** _____

_____

_____

_____

**Females:** Are you pregnant? ____Yes _____No If Yes, when due _____
Are you planning to become pregnant? _____Yes _____No
Are you nursing? _____Yes _____No

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**Past Medical History/ Family History**: Check if you or anyone in your family has:

| | Self | Relative | | Self | Relative | | Self |
|---|---|---|---|---|---|---|---|
| Skin Cancer | | | Arthritis | | | HIV | |
| Melanoma | | | Autoimmune Disease | | | Hepatitis B or C | |
| Other Cancer | | | Bleeding disorder | | | Tuberculosis | |
| Eczema | | | Diabetes | | | Positive tb test (ppd) | |
| Psoriasis | | | Gastric Ulcer | | | | |
| Keloids | | | High Blood Pressure | | | | |
| | | | Thyroid Disease | | | | |

**Current or Past Medical Problems With:**

| | Yes | No | If yes, please explain |
|---|---|---|---|
| General Health | | | |
| Allergy/Immunologic | | | |
| Eyes | | | |
| Ears/Nose/Mouth/Throat | | | |
| Heart | | | |
| Lungs | | | |
| Stomach/Gastrointestinal | | | |
| Kidneys/ Bladder | | | |
| Joints/ Arthritis/ Musculoskeletal | | | |
| Blood/ Bleeding Problems | | | |
| Blood Clot | | | |
| Neurological/ Headaches/ Seizure | | | |
| Psychiatric | | | |
| Other | | | |

**Social History:**

**Sexual Orientation:** Heterosexual (Straight) Homosexual (Gay, Lesbian) Bisexual Prefer not to say/Other

Do you drink alcohol?____Yes ____No If yes, drinks per day _____
Do you smoke? ____Yes ____No If yes, packs per day _____
If quit, what year _____
Have you ever used IV drugs? ____Yes ____No
Hobby/Leisure Activities: _____

Patient Signature: _____ Date: _____

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Patient Name: _____ DOB: _____

## AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Under HIPAA requirements, we are not allowed to give any of your health information to anyone else without your consent. Please sign below if you wish to have us leave or discuss information regarding your appointment, test results, or procedures with a member of your family. Signing this form will only allow us to discuss appointment information, test results, and procedure information with the persons listed below.

I authorize Comprehensive Dermatology Group to release appointment information, test results, and procedure information to the following individuals:

1. _____ Relation to patient: _____

2. _____ Relation to patient: _____

Patient Signature: _____ Date: _____

## AUTHORIZATION TO LEAVE A MESSAGE ON ANSWERING MACHINE

Under HIPAA requirements, we are not allowed to give any of your health information to anyone else without your consent. Please sign below if you wish to have us leave information regarding your appointment, test results, or procedures on a voicemail or answering machine. Signing this form will only allow us to leave appointment information, test results, and procedures information on the phone numbers listed below.

I authorize Comprehensive Dermatology Group to leave a message regarding appointment information, test results, or procedure information on the following answering machines/ voicemails.

1. (_____)_____

2. (_____)_____

3. (_____)_____

Patient Signature: _____ Date: _____

**We will also post the current notice on our website.**

**E. Complaints**

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

**PLEASE SIGN BELOW**

**I, _____ hereby, acknowledge receipts of the Notice of Privacy Practices given to me.**

**Sign: _____**

**Date: _____**

**If not signed, reason why acknowledgement was not obtained:**

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# Office Policy

1. **Missed Appointments:**
    - We require at least 24 business hours if you need to reschedule or cancel an appointment. A $50 charge will be applied for appointments that are not cancelled in this time frame. 48 business hours are required to cancel a surgical procedure.
    - A $100 charge ($200 charge for Mohs surgery) will be applied for surgical no shows or reschedules under the 48 business hour window.
    - Please **Do Not** rely on our automated reminder service as your only reminder to keep your scheduled appointment, as we cannot guarantee this service or that the phone number provided is accurate and functional for this purpose.
    - Please **Do Not** reply on text reminders. You must call our office to cancel your appointment.

2. **Co-Payments and Deductibles:**
    - Co-pays are due at the time of check-in for your appointment. Our office accepts credit (Visa – Master Cards) and debit cards only. We do not accept cash or checks.

3. **Insurance Cards:**
    - Please provide us with your insurance card. If you are unable to provide your insurance card, we will gladly see you as a **"Self Pay Patient".** Then, you may submit the claim to your insurance for reimbursement.

4. **Insurance Policies:**
    - As a courtesy, we will bill your primary and secondary insurance companies. However, you are ultimately responsible for payment of services not covered by your insurance plan. It is your responsibility to call and check with your insurance as to which services are covered.

5. **Out-Of-Network:**
    - It is your responsibility to make sure Comprehensive Dermatology Group is in network with your plan. If you have out-of-network benefits, we will bill your insurance as a courtesy. Please note that you will be responsible for any remaining balance.

6. **Cosmetic Services:**
    - Cosmetic services must be paid at the time of your visit. These services cannot be billed to your insurance. Cosmetic services include, but are not limited to: skin tag removal, benign growth removal, Botox, filler, peels, and laser treatments.

7. **Minor Patients:**
    - The adult accompanying a minor and the minor's parents or guardians are responsible for full payment for services rendered. Comprehensive Dermatology Group is **NOT** a party to any divorce decree. Financial responsibility for minor receiving medical services rests with accompanying adult.

8. **Collections:**
    - Comprehensive Dermatology Group will send you a statement after your insurer have been billed. If you have not received one 30 days after your visit, please contact our office. Once you receive the statement, you have 30 days from the date on the statement to dispute or pay the charges. We will charge a late fee on all outstanding balances after 30 days. If no payment is received after 120 days, your account may be turned to a collection agency.

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By signing below, you agree that you received, understand and will abide by the described office policy: Thank you.

_____

Print Name

_____ _____

Signature Date