SEASIDE DERMATOLOGY & SKIN CANCER CENTER

4950 Barranca Pkwy, Ste 307 Irvine, CA 92604
19582 Beach Blvd Ste 270 Huntington Beach, CA 92648

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PATIENT REGISTRATION FORM

Thank you for choosing our office! In order to serve you properly, please print clearly.

Today's Date:	Patient Record # (Office Use Only):

PATIENT INFORMATION

Patient's **LAST** Name:	Patient's **FIRST** Name:	Middle Initial	Sex: ❑ Male ❑ Female	Check appropriate box: ❑ Minor ❑ Single ❑Married ❑ Divorced ❑Widowed ❑Separated

Street Address:	Apt #:	City:	State:	Zip Code:

Ethnicity : Race: Primary Language:	Email Address:	Primary Phone: ❑ Home ❑Cell ( )
Birth Date (MM/DD/YYYY): Age:	Social Security #:	Driver's License #:

Occupation:	Employer Name:	Work Phone: ( )

Street Address:	City:	State:	Zip Code:

Person to Contact in Case of Emergency:
Name: Phone Number:

Primary Care Physician: Physician's Office Phone Number:

RESPONSIBLE PARTY FOR THIS ACCOUNT

(Fill out if patient is less than 18 years old)

Responsible Party Name (Last, First, Middle Initial):	Relationship to Patient (Self, Spouse,etc.):

Street Address:	City:	State:	Zip Code:

Primary Phone: ❑ Home ❑Cell ( )	Birth Date (MM/DD/YYYY):	Social Security #:

Occupation:	Employer Name:	Work Phone: ( )

Street Address:	City:	State:	Zip Code:

INSURANCE INFORMATION

No need to fill out this section if: ❑ COPY OF INSURANCE CARD ATTACHED
❑ SELF PAY(no insurance)

Primary Insurance Company Name : ❑ Patient IS the policy holder
❑ Patient IS NOT the policy holder

Subscriber Name:	Subscriber Social Security #:	Subscriber Date of Birth:
Group No:	Policy No:	Co-payment: $

Secondary Insurance Company:

Subscriber Name:	Subscriber Social Security #:	Subscriber Date of Birth:
Group No:	Policy No:	Co-payment: $

Whom may we thank for referring you to Seaside Dermatology & Skin Cancer Center? ❑ Physician ❑ Family/Friend ❑ Internet ❑ Other___________

For Medicare Patients Only - Medicare Financial Policy

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*: ___________________

Patient Name:____ Date of Birth__________________________

Release of Medical Information & Financial Policy

As stated in the Notice of Privacy Practices, I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions.

All applicable payments, deductibles, co-payments, and co-insurance will be collected at the time of service. Patients are responsible to check our participation with their plans before their visit. The patient is responsible for any/all charges not paid for by their insurance company.

I have read and understand the financial policy statement. I agree to make in-full prompt payment to Seaside Dermatology & Skin Cancer Center 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 Seaside Dermatology & Skin Cancer Center for medical insurance benefits payable to me under the terms of my policy but not to exceed the balance due for services performed for my treatments. This authorization is valid until revoked in writing.

☞*Signature*:____________________________ (Responsible Party - Patient/Guardian) *Date*: ___________________

Privacy Practices (HIPAA)

Notice of Privacy Practices

- By signing below, I acknowledge that I have been given a copy of the Notice of Privacy Practices.

☞*Signature*:_____________________________ (Responsible Party - Patient/Guardian) *Date*: ___________________

MEDICAL QUESTIONNAIRE

Reason for visit:____

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

______________________________ ______________________________ ______________________________

Are you allergic to any medications? (if yes, please list)

______________________________ ______________________________ ______________________________

Have you had any of the following conditions:

- ❑ Skin Cancer (specify):____
- ❑ Melanoma (specify): ____

Please list any relatives (father, mother, grandmother, grandfather, brother, sister) who have had any of the following conditions.

- ❑ Skin Cancer (specify):____
- ❑ Melanoma: ____

Do you take Coumadin or other blood thinners?	❑ YES	❑ NO
Do you take aspirin daily?	❑ YES	❑ NO
Do you need antibiotics before surgery or dental work?	❑ YES	❑ NO
Are you pregnant or nursing?	❑ YES	❑ NO
Are you allergic to any local anesthetic?	❑ YES	❑ NO
Do you smoke?	❑ YES	❑ NO
Do you drink alcoholic beverages?	❑ YES	❑ NO

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Financial / Payment Policies

IT IS YOUR RESPONSIBILITY TO FIND OUT WHETHER WE ARE AN
IN-NETWORK OR OUT-OF-NETWORK PROVIDER.
We do not have access to this information.

Payment is due at the time of service. Patients are to pay their deductible, copay and/or coinsurance payment at the beginning of each visit. **Please remember that you are 100 percent responsible for all charges incurred:** your physician's referral and our benefits check of your insurance benefits are not a guarantee of payment.

NOTE: Our benefits check of your insurance benefits assumes that you are in-network. Please let us know if you are seeing us out-of-network as the benefits usually differ.

Your claim will be submitted to your insurance carrier for processing based on the information you provided us. You will receive a statement for any outstanding balances.

COPAYMENTS:

Payment of a copayment only covers the cost of the office visit.
All extra procedures are charged separately.

Sample of extra procedures include but are not limited to:

- **BIOPSY (SEPARATE LAB CHARGES APPLY)**
- **FREEZING (WARTS, PRECANCEROUS LESIONS, ETC.)**
- **INJECTION OF STEROID (E.G. FOR CYSTS)**
- **INCISION AND DRAINAGE (E.G. FOR CYSTS)**
- **WOUND PACKING**
- **REMOVAL OF MOLES OR SKIN GROWTH**

DEDUCTIBLES/COINSURANCES:

A quote of deductible remaining is only an estimate based on what was provided at the time of verification by your insurance carrier.

We recommend you contact your insurance carrier and check your specialist copay and remaining deductible/ co-insurance. **This is the most accurate way to access your benefits.**
Please contact your insurance carrier with questions on how your claim was processed.

I acknowledge that I have received & read Seaside Dermatology & Skin Cancer's Financial/Payment Policies.

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Patient Name | Patient Signature | Date