SEASIDE DERMATOLOGY & SKIN CANCER CENTER

4950 Barranca Pkwy, Ste 307 Irvine, CA 92604
11100 Warner Ave Ste 350 Fountain Valley, CA 92708

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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)

Please indicate Primary versus Secondary Insurance if you have more than one 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:	

Secondary Insurance Company:		

Subscriber Name:	Subscriber Social Security #:	Subscriber Date of Birth:
Group No:	Policy No:	

Release of Medical Information & Privacy Practices (HIPAA)

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.

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

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

Patient Name:_____ Date of Birth_____

Communication Consent

I agree to allow Seaside Dermatology to contact me by phone (to the numbers given on page 1 of this registration) and in the following methods regarding my private health information, evaluation, and treatment. I authorize Seaside Dermatology to leave messages for me when I am unavailable. I understand that messages many contain confidential information and the risk associated with the different methods of communication, especially email and texting. This authorization is valid until revoked in writing.

Method	**OK to Leave Messages?**	
____ Text Message	❑ YES	❑NO
____ Email	❑ YES	❑NO

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

Preferred Pharmacy Name:_____

Preferred Pharmacy Address:_____

Preferred Pharmacy Phone number:_____

MEDICAL QUESTIONNAIRE

Reason for visit:_____

Please list any medications, herbal supplements 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 BCC/SCC):_____ ❑ Melanoma:_____

List any relatives (father,mother,brother,sister) who have had any of the following conditions:

❑ Skin Cancer (specify):_____ ❑ Melanoma:_____

❑ Autoimmune disease:_____ ❑ Elevated Cholesterol:_____

❑Psoriasis:_____

❑ Cancer: _____ ❑ Seasonal Allergies:_____

❑Diabetes:_____ ❑ Eczema:_____

What is your smoking status?

❑ Non-smoker ❑ Former smoker ❑ Current light smoker ❑ Current heavy smoker

Patient Name:_____ Date of Birth_____

MEDICAL QUESTIONNAIRE

Do you have or have had any of the following? (If yes, please check)

❑ Acne	❑ Depression	❑ Multiple Sclerosis
❑ Actinic Keratosis	❑ Down's Syndrome	❑ Pacemaker/Defibrillator
❑ Artificial Joints/Metal Implant	❑ Migraines	❑ Psoriasis
❑ Asthma	❑ Epilepsy/Seizures	❑ Seasonal allergies
❑ Atopic Dermatitis	❑ Heartburn/Ulcer/Gastritis/Reflux	❑ Thyroid Issues
❑ Atrial Fibrillation	❑ Heart disease	❑ Cancer
❑ Autoimmune disease	❑ Hepatitis/Jaundice	Type:_____
❑Bleeding disorder/Blood Clots	❑ High Blood Pressure	❑ Other Conditions:
❑ Chronic Fatigue/Fibromyalgia	❑ HIV	_____
❑ Cold Sores/Herpes	❑ Keloids or Abnormal Scarring	_____
❑ Diabetes	❑ Kidney/Liver/Lung disease	_____

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 drink alcoholic beverages?	❑ YES	❑NO
Have you been exposed to HIV?	❑ YES	❑NO
Have you been exposed to HEP A, B, C, D?	❑ YES	❑NO
Are you sexually active?	❑ YES	❑NO
Have you used tanning beds before?	❑ YES	❑NO
Do you regularly use sunscreen?	❑ YES	❑NO

Review of Body Systems

Please check if you have any of the following:

❑ **Cardiovascular**: chest pain; swelling ankles/feet	❑ **Gastrointestional**: nausea; vomitting, jaundice	❑ **Integument**: rashes, dry skin, itching
❑ **Constitutional**: weight gain, weight loss, fever, fatigue	❑ **Genitourinary:** frequent urination, burning urination, discharge	❑ **Musculoskeletal**: pain, weakness, numbnes stiffness, swelling, foot/leg cramps
❑ **Eyes**: Blurred vision; blindness	❑ **Hematologic**: bleeding, excessive bruising, using blood thinners	❑ **Respiratory**: shortness of breath, wheezing, cough

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 all applicable payments, 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 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. Please contact your insurance carrier with questions on how your claim was processed.

COPAYMENTS:

Payment of a copayment only covers the cost of the office consultation.
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)**
- **REMOVAL OF MOLES OR SKIN GROWTH**
- **WOUND PACKING**

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.**

LAB WORK:

Lab work is separately charged by the lab. If you need us to send your lab work to a specific company for in-network benefits to apply, please let our medical staff know. Otherwise, they will be sent to the standard labs used by our office.

For Medicare Patients Only: By signing below, I also 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.

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

Patient Name Patient Signature Date