Phone: (805) 434-2821
Fax: (805) 434-2526

PLATEROTI Dermatology

1101 Las Tablas Rd. Suite G
Templeton, CA 93465

PATIENT INFORMATION					
Legal First Name:	MI:	Last:		Preferred Name:	
Mailing Address:		Zip Code:	City:		State:
Driver's License #:	State:	SSN:		Date of Birth:	Gender: □ M □ F
E-mail Address:	Primary Phone: □ Cell □ Home			Secondary Phone: □ Cell □ Home	
Appointment Reminder Method: □ Text □ E-mail □ Phone	Employer:			Work Phone:	
Primary Physician:		Referring Physician (if different):			
Emergency Contact Name:		Relationship to Patient:		Primary Phone:	

Are you allergic to any medications? □ **Yes** □ **No** if yes, please list below:

List of all current medications *(including over-the-counter meds, vitamins, and herbals)*:

Name	**Strength/Unit**	**Route** *(i.e. oral, transdermal, intravenous)*	**Dose**	**Dose Form** *(i.e. tablet, liquid, topical)*	**Frequency**

Note: If you have more than seven medications please list the remaining on the backside of this page.

Pharmacy:

INSURANCE INFORMATION				
Primary Insurance: □ PPO □ Other □ HMO		Member ID:	Group #:	
Primary Subscriber's Name:		SSN:	Date of Birth:	Gender: □ M □ F
Address (if different from patient):		Relationship to Patient:		
Secondary Insurance: □ PPO □ Other □ Supplement		Member ID:	Group #:	
Secondary Subscriber's Name:		SSN:	Date of Birth:	Gender: □ M □ F

I authorize treatment for the patient named above and accept responsibility for the charges incurred for medical services. I understand that it is customary to pay for services at the time they are rendered unless other arrangements are made in advance. I authorize the release of any information contained in my records to my insurance company, if necessary, but unless notified, I am responsible for billing my insurance company. I authorize release of any information contained in my medical records to another physician's office.

Patient/Guardian Signature **Date**

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MEDICAL HISTORY AND INTAKE FORM

PATIENT NAME:	DATE:

PAST MEDICAL HISTORY: (CIRCLE ALL THAT APPLY)

ANXIETY DISORDER
ARTHRITIS
ASTHMA
ATRIAL FIBRILLATION (IRREGULAR HEARTBEAT)
BENIGN PROSTATIC HYPERPLASIA
CEREBROVASCULAR ACCIDENT
CHRONIC OBSTRUCTIVE LUNG DISEASE
CORONARY ATERIOSCLEROSIS
DEPRESSIVE DISORDER
DIABETES MELLITUS
ELEVATED BLOOD PRESSURE
END-STAGE RENAL DISEASE
EPILEPSY
GASTROESOPHAGEAL REFLUX DISEASE (GERD)
OTHER:

HEARING LOSS
HUMAN IMMUNODEFEFIENCY VIRUS INFECTION
HYPERCHOLESTEROLEMIA
HYPERTHYROIDISM
HYPOTHYROIDISM
INFLAMMATORY DISEASE LIVER
LEUKEMIA
MALIGNANT LYMPHOMA (CLINICAL)
MALIGNANT TUMOR OF LUNG
MALIGNANT TUMOR OF BREAST
MALIGNANT TUMOR OF COLON
MALIGNANT TUMOR OF PROSTATE
RATIATION THERAPY TREATMENT MANAGEMENT
TRANSPLANTATION OF BONE MARROW
NONE OF THE ABOVE

PAST SURGICAL HISTORY: (CIRCLE ALL THE APPLY)

ABDOMINOPERINEAL RESECTION
BILATERAL REPLACEMENT OF KNEE JOINTS
BIOPSY OF BREAST
BIOPSY OF PROSTATE
CORONARY ARTERY BYPASS GRAFT
ENTIRE TRANSPLANTED KIDNEY
EXCISION OF BASAL CELL CARCINOMA
EXCISION OF MELANOMA
EXCISION OF SQUAMOUS CELL CARCINOMA
HISTORY OF COLOSTOMY
HISTORY OF TUBAL LIGATION
HISTORY OF APPENDECTOMY
HISTORY OF BILATERAL MASTECTOMY
HISTORY OF CHOLECYSTECTOMY
HISTORY OF COLECTOMY
HISTORY OF LIVER EXCISION
HISTORY OF PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY
HISTORY OF TISSUE GRAFT HEART VALVE REPLACEMENT
HISTORY OF TOTAL CYSTECTOMY
HISTORY OF TRANSURETHRAL PROSTATECTOMY
HYSTERECTOMY
KIDNEY BIOPSY
LOW ANTERIOR RESECTION OF RECTUM
OTHER:

LUMPECTOMY OF BREAST
LUMPECTOMY OF LEFT BREAST
LUMPECTOMY OF RIGHT BREAST
MASTECTOMY OF LEFT BREAST
MASTECTOMY OF RIGHT BREAST
MECHANICAL HEART VALVE REPLACEMENT
OOPHORECTOMY
PANCREATECTOMY
PERCUTANEOUS EXTRACTION OF KIDNEY STONE
PORTOSYSTEMIC SHUNT OPERATION
PROSTATECTOMY
PROSTHETIC ARTHROPLASTY OF BILATERAL HIPS
SPLENECTOMY
SURGICAL BIOPSY OF SKIN
TOTAL NEPHRECTOMY
TOTAL ORCHIDECTOMY
JOINT REPLACEMENT: HIP (LEFT)
JOINT REPLACEMENT: KNEE (LEFT)
JOINT REPLACEMENT: HIP (RIGHT)
JOINT REPLACEMENT: KNEE (RIGHT)
TRANSPLANTATION OF HEART
TRANSPLANTATION OF LIVER

NONE OF THE ABOVE

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SKIN DISEASE HISTORY: (CIRCLE ALL THAT APPLY)

ACNE
ACTINIC KERATOSES
ASTEATOSIS CUTIS
BASAL CELL CARCIMOMA OF SKIN
CONTACT DERMATITIS DUE TO POISON IVY
DYSPLASTIC NAEVUS OF SKIN
ECZEMA
OTHER:

HISTORY OF ASTHMA
HISTORY OF HAY FEVER/ALLERGIES
MALIGNANT MELANOMA
PRURITUS OF SCALP
PSORIASIS
SQUAMOUS CELL SKIN CARCINOMA
SUNBURN OF SECOND DEGREE
NONE OF THE ABOVE

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 malignant melanoma? **YES / NO**
If yes, which relative(s)? _____

TOBACCO SMOKING STATUS: (CIRCLE ALL THAT APPLY)

CURRENT EVERY DAY SMOKER
CURRENT SOME DAY SMOKER (CIGARETTE)
FORMER SMOKER
NEVER SMOKER

SOCIAL HISTORY DETAILS: (CIRCLE ALL THAT APPLY)

ALCOHOL: NONE
ALCOHOL: LESS THAN 1 DRINK PER DAY
ALCOHOL: 1-2 DRINKS PER DAY
ALCOHOL: 3 OR MORE DRINKS PER DAY

MIPS QUESTIONNAIRE

Have you received your influenza immunization? **YES / NO** If no, reason: _____

If you are an adult **50 years of age or older**, have you received the Shingrix (Shingles) vaccine? **YES / NO**
If no, reason: _____

If you are an adult **65 years of age or older**, have you received a pneumonia vaccination? **YES / NO**

If you are an adult **65 years of age or older**, how many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women? _____

DO YOU HAVE A FAMILY HISTORY OF ANY OTHER SKIN CANCERS OR ANY OTHER CANCERS? YES / NO
IF YES, PLEASE SPECIFY TYPE AND RELATIVE: _____

_____

PATIENT/GAURDIAN SIGNATURE: _____ DATE: _____

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FINANCIAL AGREEMENT AND OFFICE POLICIES

Consent to Pay for Services Rendered: Payment is required for all services at the time the services are performed. If we are contracted providers (in-network) with your insurance plan, we are required by contract to collect your copayment/coinsurance and any unmet deductible. It is **your** responsibility to verify if we are a contracted provider and to understand your coverage benefits under your policy.

- Insurance coverage, authorization, and pre-certification are not guarantees of payment by your insurance company. If your insurance fails to respond or does not respond promptly, we will forward the balance to you for payment.
- If we provide services to you that are not covered by your health plan, you will be responsible for payment at the time the services are performed. Should your insurance company pay after you have already paid us, we will promptly refund you.
- We accept check, Visa, MasterCard, Discover, American Express, and Care Credit for your convenience. Aesthetic services are on a cash or credit card service only.

Office Policies: We will call to confirm most appointments at least 24-hours in advance. If you are more than 15 minutes late by our clock, you may be asked to reschedule your appointment. Cancellations must be made 24-hours prior to your appointment. Children under the age of 18 must be accompanied by a parent or guardian. If the parent or guardian is not present, a minor consent form must be signed. Medical records may be viewed online via your patient portal. If you would like access to your patient portal, please see the front desk for more information. Otherwise, a physical copy of your medical records can be requested for a $25 clerical fee.

We charge $50.00 for missed appointments, including aesthetics.
We have a 24-hour answering service available for cancellations. You may call our main number at (805) 434-2821.

A fee of $200.00 may apply if a 24-hour notice is not given for surgical procedures.
Cancellations for surgical appointments including MOHS surgery must be made 24-hours prior to your appointment.

Please read and initial the following specifics regarding our payment and collection processes.

_____ (Initial) I understand I will be responsible for any remaining balance not covered by my insurance company within 30 days of receiving my statement.

_____ (Initial) I understand that procedures performed in this office are often separate, billable services that are not included in the office visit. I understand that many insurance companies apply these procedures to a deductible or coinsurance and may not be covered under the copayment. I am responsible for any unmet deductible or coinsurance at the time of service. It is my responsibility to know and understand what my policy benefits are with my insurance company.

_____ (Initial) I understand that if I have a surgical procedure or biopsy done at Plateroti Dermatology, there are two charges. First is the provider charge for collecting the biopsy. The second charge is to examine the specimen by a pathologist, chosen by my attending physician. I will be billed separately for these pathology charges by the pathologist who does the reading.

_____ (Initial) I understand that my insurance company may have a preferred laboratory for blood work. It is my responsibility to know which preferred laboratory company I need to use. It is also my responsibility to inform my provider of this at the time services are rendered.

_____ (Initial) Plateroti Dermatology refers delinquent accounts to Action Professionals collection agency. Once my account is delinquent and sent to collections, I will be dismissed from the practice.

_____ (Initial) I understand that a $35 returned check fee will be applied to my account for any checks returned by my financial institution. I also understand that payment of the check and fee will be due immediately and I will no longer be able to issue a check as payment to the practice.

_____ (Initial) I have read the above financial and office policies and agree to meet my financial obligation in accordance with these policies. I hereby authorize any insurance company to pay Dermatology Associates of the North County. A copy of this authorization can be considered an original for insurance purposes.

Patient/Guardian Signature **Date**

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

I give permission to release medical information that may include, but not limited to, appointments, prescriptions, and test results to the following designated people. I understand that due to HIPAA guidelines, medical information will only be discussed with me and those listed below.

1._____ Relationship: _____ Ph#:_____

2._____ Relationship: _____ Ph#:_____

3._____ Relationship: _____ Ph#:_____

I give permission to have telephone messages left on answering machine: □ **Yes** □ **No**

I give permission to have mail sent to my home address: □ **Yes** □ **No**

I give permission to leave MESSAGES/CALL BACK NUMBERS at my work: □ **Yes** □ **No**

Work #: _____

I give permission to have my records faxed wherever I choose at my request: □ **Yes** □ **No**

Signature of Patient/Guardian: _____ Date: _____

MINOR PATIENT CONSENT

I, _____, from this date forward give permission to Dr. Carmelo Plateroti's office to treat my son/daughter, _____ without the presence of a parent or guardian.

Signature of Guardian: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under Heath Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____

Patient Name (Print)

_____

Signature of Patient or Guardian **Date**

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Staff Initials:	Reason:

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Aesthetics Skin Care & Treatment Questionnaire **(Optional)**

First/Last Name: _____ DOB:_____

☐ **Please send me monthly/ specials via Email: _____**

Would you like to schedule a Free 15 minute, *Complimentary* Consult to discuss solutions to your concerns?

- ☐ **YES, TODAY IF POSSIBLE**
- ☐ **YES, AT A LATER DATE**
- ☐ **NOT AT THIS TIME, THANK YOU**
- ☐ **OTHER _____**

THANK YOU FOR YOUR INTEREST IN RECEIVING A CONSULT. PLEASE COMPLETE THE FOLLOWING QUESTIONS:

When looking in the mirror, I am:

- ☐ Not concerned about the appearance of my skin
- ☐ Somewhat concerned about the appearance of my skin
- ☐ Very concerned about the appearance of my skin

I'm interested in learning more about the following treatments to improve the following areas:

- ☐ Fine Lines/Wrinkles
- ☐ Texture/Creepy Skin
- ☐ Stretch Marks/Birthmark Reduction
- ☐ Neck Fullness (Double Chin) Reduction
- ☐ Sun/Age Spot Treatment
- ☐ Acne and Acne Scarring
- ☐ Rosacea/Red Facial Vessels
- ☐ Spider Vein Treatment
- ☐ Thinning Eyelashes (length/fullness)
- ☐ Advanced Skin Care Regimen
- ☐ Thinning or Balding Hair
- ☐ Hair Reduction Laser Treatments: What area(s) of the body? _____
- ☐ Other, please specify: _____

What is your current skin care routine? (i.e: Cleanser, SPF, moisturizer)?

AM: _____

PM: _____

We're here for all your skin care needs!

Office Use Only:

Consulted _____(Int)

Patient Scheduled for Consult _____(Int)

Patient Scheduled Aesthetic Treatment _____(Int)

Other _____ _____(Int)

Scanned Questionnaire _____ CC _____ EMA _____(Int)

Email Added (Constant Contact) _____(Int)

Future Aesthetic Appointment

Date_____

Date_____

Medical Appointment Date: _____

Date Received: _____