DERMATOLOGY & LASER CENTER OF SAN DIEGO

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Patient Registration Information

Patient Name _____ D.O.B. ____/____/____ Sex _____ Marital Status _____

Address _____ Social Security # _____ – _____ – _____

City _____ State _____ Zip _____ Home # (_____)_____ – _____

Employer/Occupation _____

Work # (_____)_____ ext. _____ Drivers License # _____ Expires _____

E-Mail _____ Cell Phone (_____)_____

Race _____ Ethnicity _____ Language _____

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Responsible Party _____ Social Security # _____ – _____ – _____

Address _____ City _____ State _____ Zip _____

Home # (_____)_____ – _____ Relationship to patient _____

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Referral Source (physician, etc..) _____ Phone # (_____)_____ – _____

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Emergency contact not living with you _____ Phone # (_____)_____ – _____

Address _____ City _____ State _____ Zip _____

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Primary Ins. _____ Secondary Ins. _____

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All services rendered are payable on the day of the visit. If insured, as a courtesy, your claim will be submitted to your insurance; however, any co-pay, deductible or patient portion is payable upon the day of service.

I understand that I am financially responsible for all charges whether or not they are covered. I authorize payment of medical benefits to the assigned physician and the release of medical information necessary to secure the payment of benefits.

I understand that if my account becomes delinquent, I will be held responsible for reasonable attorney's fees, court costs, and collection costs. I am aware that I may be charged a fee for appointment missed without 24 hours prior notice.

Date _____ Signature _____

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I hereby voluntarily consent to medical treatment as deemed necessary by the physician. Some treatments may be administered by medical assistants and/or designees under the physician's directions and supervision.

I hereby authorize the direct DERMATOLOGY & LASER CENTER OF SD having treated me, to release to governmental agencies, insurance carriers, attorneys or other who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

Date _____ Signature _____

319 F. Street #102 • Chula Vista, CA 91910 • Ph. 619-476-1200 • Fax 619-420-7849
4060 Fourth Avenue #209 • San Diego, CA 92103 • Ph. 619-298-9535 • Fax 619-298-9591
6386 Alvarado Court #205 • San Diego, CA 92120 • Ph. 287-2877 • Fax 287-2121 www.dermlasercenter.com

INITIAL PATIENT QUESTIONNAIRE

NAME _____ AGE _____ OCCUPATION _____

REFERRING PHYSICIAN _____ PRIMARY CARE PHYSICIAN _____

***DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? (Please list)** _____

***ARE YOU ALLERGIC TO LOCAL ANESTHETICS? (Novocaine/Lidocaine)** _____

Please describe your skin problem (duration and treatment) _____

_____

_____

Is your condition work related? YES NO

Other skin problems _____

Please list medical illnesses _____

Please list current medications _____

_____

_____

Do you smoke? YES/NO Are you a diabetic? YES/NO Do you take insulin? YES/NO

Do you or have you: (Please circle YES or NO)

Heal with thick or wide scars? YES/NO
Bleed easily? YES/NO
Take aspirin or blood thinner? YES/NO
Need to take antibiotics before surgery? YES/NO
Had skin cancer? YES/NO

Had malignant melanoma? YES/NO
Had a family member with malignant melanoma? YES/NO
Been exposed to radiation? YES/NO
Had asthma, eczema or hayfever? YES/NO
Had any family members with asthma, eczema or hayfever? YES/NO

FEMALE PATIENTS

Pregnant? YES/NO LMP: _____ Method of birth control _____

CURRENT SKIN CARE REGIMEN

Your facial skin type: OILY / COMBINATION / DRY / SENSITIVE

Your facial skin type: _____

Moisturizer _____

Sunscreen _____

Would you like further information on: (Please circle)

*Scar improvement
*Laser skin resurfacing
*Fillers
*Tattoo removal
*Skin tightening
*Fat reduction
*Chemical peels
*Botox (frown line) treatments
*Blepharoplasty (eyelid lifts)
*Spider & varicose vein removal
*Resurfacing lasers
*Microneedling
*Crystal peel (microdermabrasion)
*Hair growth treatments
*Pigmentation improvement
*Wrinkle & removal
*Platelet rich plasma (PRP)

Confidential Channel Communication Request

Dermatology & Laser Center of SD
319 F Street, Suite 102, Chula Vista, CA 91910 • 4060 Fourth Ave, Suite 209, San Diego, CA 92103
6386 Alvarado Court, Suite 205, San Diego, CA 92120
Office Manager/Privacy Officials 619-476-1200

As required by the Health Information Portability and Accountability Act of 1996 you have a right to request and that communications concerning your personal health information be made through confidential channels. Dermatology & Laser Center of S.D. will not ask why you are making your request, and will make efforts to accomodate all reasonable requests. Some methods of contact must be provided, and as appropriate, information as to how payment will be handled.

I, _____ (print name) hereby request the use of the following confidential channel for the communication of information related to my personal health, treatment or payment for treatment. **This request supercedes any prior request for confidential channel communications I may have made.**

Please select all that apply: Where you list more than one communication option, please indicate which you prefer.

☐ **Phone**
I want you to contact me by telephone at _____

☐ Do	☐ Do Not	leave a message on my answering machine.
☐ Do	☐ Do Not	leave a message with any other person.
☐ Do	☐ Do Not	leave a message via text.

☐ **Mail**
I want you to contact me at the following address: _____

_____

☐ **E-Mail**
I want you to contact me at the following e-mail address: _____

☐ **Fax**
I want you to contact me at the following fax number: _____

☐ **Other**

_____

Signed: _____ Date: _____

Print Name: _____
If not signed by patient, please indicate Relationship:

- ☐ parent or guardian of a minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

****

For office use only:

Date Granted: _____
Date Terminated or Modified: _____

ACKNOWLEDGMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature