



Aloha & Welcome to Matsuda Dermatology

Thank you for allowing us to serve your Medical and Cosmetic dermatology needs. The following information is provided to introduce you to our practice and our practice policies.

Please complete the **Patient Registration** and **Dermatology Medical History** forms and/or the **Telemedicine Consent**, and return them via email to staff@matsudadermatology.com or text to 949-7568, or mail to 405 N. Kuakini St, #703, Honolulu, HI, 96817. Please make sure we receive your forms at least **48–72 hours prior to your appointment date**. This will help to ensure that the check-in process is done in an efficient and timely manner, and your chart is ready by your appointment time. Please note, if we do not receive your completed forms at least 48 hours prior to your appointment date, your appointment will be automatically rescheduled to the next available date.

If you have medical insurance, please bring all of your current insurance cards and a valid photo identification with you to your appointment. Please check to make sure that your cards are not expired. We recommend that you contact your insurance company prior to your appointment to verify that our office is contracted with your particular health plan. You may do this by calling the (800) telephone number on the back of your insurance card.

Please bring in any required co-payments to your office visit, as it will be collected at the time of check out. For self-pay patients, payment in full at the time of service is required, unless otherwise discussed. We accept cash, Visa/Mastercard/Discover debit and credit cards

If you need to cancel or reschedule your appointment, please give us notice at least 48 business hours prior to your appointment date. Failure to give proper notification may result in a \$50 fee and/or suspension of services.

Thank you! We look forward to meeting you soon.

MATSUDA DERMATOLOGY PATIENT REGISTRATION FORM

Today's Date:			
PATIENT INFORMATION			
Last Name:	First:	Middle:	Birth Date: / / Gender:
Address:		City:	State: Zip Code:
Primary Phone:	Mobile Phone:	Text messaging? <input type="checkbox"/> Yes <input type="checkbox"/> No	Email address:
Work Phone:		Social Security Number:	
CMS (MEDICARE) MANDATE			
<i>As part of a Mandate by CMS (Medicare), in conjunction with reporting by Electronic Reporting Date, the following information is required to be obtained and will be used for reporting purposes only.</i>			
Preferred Contact Method: <input type="checkbox"/> Mobile Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> E-mail <input type="checkbox"/> Written (mail)			
Primary Language:			
Race: <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White or Caucasian		Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino	
MINOR PATIENT (IF UNDER 18 YEARS OF AGE)			
Name of Father or Legal Guardian:		Mobile Phone:	Employer: Work Phone:
Name of Mother or Legal Guardian:		Mobile Phone:	Employer: Work Phone:
EMERGENCY CONTACT INFORMATION			
Contact Name:		Relationship:	Phone: (home or mobile)
1.			
2.			
INSURANCE INFORMATION			
Primary Insurance:		Policy ID Number:	Group Name or Number:
Name of Insured (Guarantor):		Guarantor Birth Date: / /	Patient's relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:
Secondary Insurance:		Policy ID Number:	Group Name or Number:
Name of Insured (Guarantor):		Guarantor Birth Date: / /	Patient's relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:
AUTHORIZATION FOR RELEASE OF PERSON HEALTH INFORMATION TO AUTHORIZED PERSONS BY PATIENT			
It is our policy NOT to release confidential medical information to family members or friends , except for parent and/or legal guardian, if the patient is a minor, or as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).			
If you anticipate that you will need or want your medical information to be provided to family members or other persons, please complete the following information.			
<input type="checkbox"/> Check this box if you <u>DO NOT</u> want your medical information to be provided to family members or other persons, then sign at the bottom.			
I hereby authorize Matsuda Dermatology to disclose:			
<input type="checkbox"/> All my health information <input type="checkbox"/> Insurance and billing information <input type="checkbox"/> Other:			
To the following authorized person(s):			
Authorized person #1:		Relationship:	Phone number:
Authorized person #2:		Relationship:	Phone number:
I may revoke this authorization in writing and it will not affect any actions already taken by Matsuda Dermatology based upon this authorization.			
Signature _____			Date _____

MATSUDA DERMATOLOGY PATIENT REGISTRATION FORM

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices is a condensed version of our *Notice of Privacy Practices*. Our full-length notice is made available upon request by the patient.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is private and personal, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to ensure that your Protected Health Information is kept private.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation. Examples of this are as follows:

- ♦ For medical treatment
- ♦ To obtain payment for services
- ♦ For appointment and patient reminders
- ♦ To run a more efficient practice and ensure our patients receive quality care
- ♦ In response to certain requests arising from lawsuits or other disputes
- ♦ For research
- ♦ In emergency situations
- ♦ To avert serious threat to health or safety

If you believe that your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- ♦ The right to inspect and copy
- ♦ The right to amend
- ♦ The right to a paper copy of this notice
- ♦ The right to request restrictions
- ♦ The right to an accounting of disclosures
- ♦ The right to request confidential communications

For more information about these rights, please see the detailed *Notice of Privacy Practices* available by our office.

**Acknowledgement of Receipt of Notice of Uses and Disclosures of Protected Health Information
Authorization for Treatment, Release of Information, Assignment of Benefits and Acknowledgement of
Responsibility for Payment for Physician Services**

- I have read the Summary of Privacy Practices. I was informed that I may also obtain a printed copy of the *Notice of Privacy Practices* from the office. I hereby acknowledge that I received a copy of *the Notice* from Matsuda Dermatology (Stella S. Matsuda, M.D., Inc.)
- I hereby give consent to Matsuda Dermatology (Stella S. Matsuda, M.D., Inc.) to provide whatever treatment is deemed necessary.
- I authorize any holder of medical information to release to my insurer and its agents, physicians, hospitals and other medical providers any information needed to determine benefits payable for these and related services.
- I allow facsimile (fax) transmittal of my medical records, if necessary.
- I request that payment of authorized Medicare and other insurance benefits be made to me or on my behalf to the physician of Stella S. Matsuda, MD, Inc. for any services furnished me. This assignment will remain in effect until revoked by me in writing.
- I understand that payment of charges (i.e. co-payments, balance after insurance payment received, etc.) incurred is due at time of service unless other definite financial arrangements have been made prior to treatment.
- I understand that a late monthly fee of 1.5% or 50 cents minimum will be charged to all accounts past 60 days. I understand that I am financially responsible for all charges incurred and, in the event that insurance payments are sent directly to me, I will remit payment to this office. If my insurance does not pay all bills submitted, I acknowledge that these bills are my responsibility and will guarantee payment.
- I further agree to pay any reasonable cost, including attorney and collection agency cost, in the event my account becomes delinquent.

I agree to give at least 48 business hours notice for all cancellations. I understand that failure to give proper notification or missed appointments may result in a service fee of \$50.00 and/or suspension of services. _____ (Initial)

I have read and fully understand the above consent for treatment, financial responsibility, release of information and insurance authorization. I also acknowledge receipt of Notice of Uses and Disclosures of Protected Health Information.

Signature _____ Date _____

MATSUDA DERMATOLOGY MEDICAL HISTORY FORM

Today's Date:	How did you hear of our practice? (circle option) Doctor / Friend / Internet / Other		
PATIENT INFORMATION			
Last Name:	First:	Middle:	Birth Date: / / Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			Primary Pharmacy:
Primary Care MD/PA/NP:		Referring MD/PA/NP:	
Employer:	Occupation/Title:	Work Phone:	

REASON FOR TODAY'S VISIT			
Concern:	Location:	Duration:	Past treatments:
Concern:	Location:	Duration:	Past treatments:

MEDICATION ALLERGIES		
Do you have any medication allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
List allergies and reactions:	Allergies:	Reactions:

CURRENT MEDICATIONS					
Medication:	Dose:	Medication:	Dose:	Medication:	Dose

PAST MEDICAL HISTORY			
Adhesive tape allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Latex allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV positive	<input type="checkbox"/> Yes <input type="checkbox"/> No
Local anesthesia allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No	MRSA	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epinephrine sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal scars	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bacitracin allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Poor wound healing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Neosporin allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fever blister / cold sore	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other allergies:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anticoagulant treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial heart valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemaker / defibrillator	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral valve prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Immunosuppressed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Organ transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psoriasis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sun sensitivity / rashes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Acid reflux	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pro-op / pre-dental antibiotics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hair / Nail problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Memory problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	New / changing / abnormal moles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting / syncope	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer(s), other than skin cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Previous surgery:	<input type="checkbox"/> Yes <input type="checkbox"/> No	List:	
Other medical problems:	<input type="checkbox"/> Yes <input type="checkbox"/> No	List:	

SKIN CANCER HISTORY

Do you have a history of melanoma?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a history of skin cancer(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

FOR WOMEN ONLY

Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you trying to get pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you breastfeeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you on birth control?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a regular menstrual cycle?	<input type="checkbox"/> Yes <input type="checkbox"/> No

FAMILY HISTORY

Do you family history of melanoma?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have family history of skin cancer(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have family history of cancer(s), other than skin cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have family history of eczema, asthma, seasonal allergies, psoriasis, autoimmune diseases (lupus, rheumatoid arthritis, thyroid disease)? If yes, circle above or list:	<input type="checkbox"/> Yes <input type="checkbox"/> No

SOCIAL HISTORY

Do you use sunscreen?	<input type="checkbox"/> None <input type="checkbox"/> Occasionally <input type="checkbox"/> Daily
Tanning bed use?	<input type="checkbox"/> None <input type="checkbox"/> Current <input type="checkbox"/> Previous
Do you use tobacco?	<input type="checkbox"/> None <input type="checkbox"/> Yes <input type="checkbox"/> Former smoker. Year you quit _____ <input type="checkbox"/> Daily <input type="checkbox"/> Occasionally
Alcohol consumption?	<input type="checkbox"/> None <input type="checkbox"/> Yes, how often: <input type="checkbox"/> 1x month or less <input type="checkbox"/> 2-4x/month <input type="checkbox"/> 2-3x/week <input type="checkbox"/> 4+/week <input type="checkbox"/> Daily: <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-6 <input type="checkbox"/> 7+
Drug / Illegal substance use?	<input type="checkbox"/> None <input type="checkbox"/> Yes: <input type="checkbox"/> Marijuana <input type="checkbox"/> Other:

CURRENT MEDICAL PROBLEMS OR CONDITIONS

Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chills / Night sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easy bruising	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood clots	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unintentional weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen lymph nodes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye irritation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rash / itch	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nausea / vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No		

PLEASE INDICATE ANY COSMETIC CONCERNS

<input type="checkbox"/> Wrinkles	<input type="checkbox"/> Facial redness	<input type="checkbox"/> Tattoo removal
<input type="checkbox"/> Sagging skin	<input type="checkbox"/> Acne scarring	<input type="checkbox"/> Hair removal
<input type="checkbox"/> Sun damage	<input type="checkbox"/> Large pores	<input type="checkbox"/> Other:
<input type="checkbox"/> Brown spots	<input type="checkbox"/> Scars	
<input type="checkbox"/> Age spots	<input type="checkbox"/> Stretch marks	<input type="checkbox"/> Thanks, but no interest at this time

I understand the information above is an important part of my medical care and well-being, and I have answered all of the above questions truthfully and to the best of my abilities.

Signature of Patient, Parent or Legal Guardian (if patient is a minor under 18 years old)

Date