MATSUDA
DERMATOLOGY
405 N Kuakini Street, Suite 703
Honolulu, HI 96817
(808) 949-7568

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? ☐ Yes ☐ No	Email address:	
Work Phone:			Social Security Number:	

CMS (MEDICARE) MANDATE

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.

Preferred Contact Method: ☐ Mobile Phone ☐ Home Phone ☐ Work Phone ☐ E-mail ☐ Written (mail)

Primary Language:

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White or Caucasian

Ethnicity: ☐ Hispanic/Latino ☐ 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: ☐ Self ☐ Spouse ☐ Child ☐ Other:
Secondary Insurance:	Policy ID Number:	Group Name or Number:
Name of Insured (Guarantor):	Guarantor Birth Date: / /	Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ 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.

☐ **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:

☐ All my health information ☐ Insurance and billing information ☐ 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
- For research
- In emergency situations
- To avert serious threat to health or safety
- To run a more efficient practice and ensure our patients receive quality care
- In response to certain requests arising from lawsuits or other disputes

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 <u>48 business hours</u> notice for all cancellations. I understand that failure to give proper notification or <u>missed appointments</u> 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:
Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐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?	☐ Yes ☐ No	
List allergies and reactions:	Allergies:	Reactions:

CURRENT MEDICATIONS

Medication:	Dose:	Medication:	Dose:	Medication:	Dose

PAST MEDICAL HISTORY

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

SKIN CANCER HISTORY	
Do you have a history of melanoma?	☐ Yes ☐ No
Do you have a history of skin cancer(s)?	☐ Yes ☐ No

FOR WOMEN ONLY	
Are you pregnant?	☐ Yes ☐ No
Are you trying to get pregnant?	☐ Yes ☐ No
Are you breastfeeding?	☐ Yes ☐ No
Are you on birth control?	☐ Yes ☐ No
Do you have a regular menstrual cycle?	☐ Yes ☐ No

FAMILY HISTORY	
Do you family history of melanoma?	☐ Yes ☐ No
Do you have family history of skin cancer(s)?	☐ Yes ☐ No
Do you have family history of cancer(s), other than skin cancer?	☐ Yes ☐ 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:	☐ Yes ☐ No

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

CURRENT MEDICAL PROBLEMS OR CONDITIONS			
Fever	☐ Yes ☐ No	Constipation	☐ Yes ☐ No
Chills / Night sweats	☐ Yes ☐ No	Easy bruising	☐ Yes ☐ No
Fatigue	☐ Yes ☐ No	Blood clots	☐ Yes ☐ No
Unintentional weight loss	☐ Yes ☐ No	Swollen lymph nodes	☐ Yes ☐ No
Eye irritation	☐ Yes ☐ No	Joint pain	☐ Yes ☐ No
Chronic cough	☐ Yes ☐ No	Rash / itch	☐ Yes ☐ No
Shortness of breath	☐ Yes ☐ No	Headache	☐ Yes ☐ No
Nausea / vomiting	☐ Yes ☐ No	Anxiety	☐ Yes ☐ No
Abdominal pain	☐ Yes ☐ No	Depression	☐ Yes ☐ No
Diarrhea	☐ Yes ☐ No		

PLEASE INDICATE ANY COSMETIC CONCERNS		
☐ Wrinkles	☐ Facial redness	☐ Tattoo removal
☐ Sagging skin	☐ Acne scarring	☐ Hair removal
☐ Sun damage	☐ Large pores	☐ Other:
☐ Brown spots	☐ Scars	
☐ Age spots	☐ Stretch marks	☐ **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