Luminous Dermatology

contact@luminousderm.com

504 W. Pueblo St., Ste. 102, Santa Barbara, CA 93105
Tel. 805-682-6455 Fax. 805-687-1482

2151 S. College Dr. Ste. 105, Santa Maria, CA 93455
Tel. 805-934-1230 Fax. 805-934-2271

Bryan L. Gammon, M.D. Loebat Julia Kamalpour, M.D. Kate Tadlock, MPAS, PA-C Lam Q. Le, PA-C

Patient Information:

Patient Name_____

Address_____ City_____ State_____ Zip _____

Home #. (___) _____ Work #. (___)_____ Cell #. (___) _____

Email Address: _____

Prefer we contact you by: Cell_____Home_____Work_____Email_____

Birth Date _____ Age_____ Sex_____ Driver License #_____

SS# _____ Marital Status _____ Spouse's Name _____

Employer/Occupation _____ Student: Full time_____ Part time_____

Emergency contact: Full Name :_____

Relationship to pt._____Tel. #. _____

Referral information:

Who referred you to us? _____

Primary Physician's Name _____ Tel. # _____

Race: Caucasian____ Asian/Pacific Islander_____ Other _____ Refuse to provide____
Ethnicity: Hispanic/Latino___ African_____American Indian_____ Other_____ Refuse to provide _____
Pref. Language: English____ Spanish___ Other _____

Insurance Information:

Name and date of birth of policy subscriber:_____

Initial applicable statement

___ **Bill my insurance plan.** I have provided my insurance information to office staff. I will pay applicable co-payment and charges for non-covered services at time of service and be billed for any balance remaining after insurance consideration.
___ **Out of network.** It is my understanding Luminous Dermatology does not participate with my insurance. I agree payment is expected at time of appointment and insurance claim submission is my responsibility.
___ **I will pay at time of service.** I do not wish to provide insurance information.

Responsible party:

Name_____ Relationship_____
Mailing Address_____
Home Phone (___)_____ Work Phone (___)_____ Cell Phone (___)_____
Birth date_____ Sex_____ SS# _____-_____-_____ DL# _____

I understand the office financial policy requires payment in full at time of service unless services are covered by an insurance plan in which Luminous Dermatology has a participating agreement. I understand charges for treatment are my responsibility, regardless of insurance. I authorize release of medical records to my physician and insurance company.

Signature of Patient or Responsible Party _____ **Date**_____

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NO SHOW/ CANCELLATION POLICY AGREEMENT

The purpose of this agreement is to give you a clear understanding of our policy concerning a $40.00 fee for appointments not cancelled 24 hours in advance and for patients who have no-showed for their appointment.

This agreement has no expiration date**.**

I hereby authorize Luminous Dermatology to charge my account $40.00 should I fail to cancel an appointment 24 hours in advance or no-show for a scheduled appointment.

NAME:
_____DATE:_____

****

DO WE HAVE YOUR PERMISSION TO:

Leave a message on your answering machine? **O** Yes **O** No

Leave a message at your place of employment? **O** Yes **O** No

Discuss your medical condition? **O** Yes **O** No

If yes, with whom? _____ Relationship: _____

HIPPA / Acknowledgement of Receipt of Notice of Privacy Practices

☐ **Accept a copy**.
I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at future appointments if applicable.

or

☐ **Decline a copy.**
I have chosen to waive my right to a copy of this medical practice's Notice of Privacy Practice. I understand a copy of the current notice will be posted in the reception area and that I have the option to request a copy at a later date if I so choose.

Signature: _____ **Date:**_____

If not signed by the patient, please indicate relationship:

O parent or guardian of minor patient O guardian or conservator of an incompetent patient

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What Skin Concerns Bring You to the Office? _____
Drug Allergies_____
Current Medications _____
Last Physical Examination _____
Smoker: Current smoker ___ Never smoked___ Former smoker___
Alcohol Use: Denies use ___ Socially___ Daily___ Preferred Pharmacy: _____

Patient Past Medical History (circle all that apply)

None	Anxiety	Arrhythmia	Asthma	BPH
Bleeding Disorder	Breast Cancer	Bronchitis/COPD	Cancer	Cerebral Palsy
Chest Pain/Tightness	Dementia	Depression	Diabetes	Eczema
GERD	Glaucoma	Gout	Heart Disease	Heart Murmur
Hepatitis/HIV	High Blood Pressure	Hives	Hyperlipidemia	Incontinence
Kidney Disease	Kidney Stones	Lymphoma	Multiple Sclerosis	Osteoarthritis
Osteoporosis	Parkinson's disease	Rheumatoid Arthritis	Seasonal Allergies	Sjogren's Syndrome
Stroke	Thyroid Disorder	Tuberculosis	Ulcers	Xray Therapy

Other: _____

Patient Past Surgeries/Hospitalizations

Surgery/Hospitalizations	Date	Anesthesia Complications	Notes

Skin History (circle all that apply)

None	Acne	Actinic Keratosis	Basal Cell Carcinoma
Bullous Pemphigoid	Eczema	HSV	Lichen Planus
Lichen Sclerosus	Malignant Melanoma	Psoriasis	Rosacea
Sjogren's	Squamous Cell Carcinoma	Urticaria	Vitiligo

Patient Family History (circle all that apply. Note afflicted family member)

None	Abnormal Bleeding	Abnormal Clotting	Adopted	Autoimmune Disorders
Brain Tumor	Breast Cancer	Diabetes	Eczema	Endocrine Disease
Heart Disease	Hemophilia	High Blood Pressure	Kidney Disease	Liver Disease
Lung Cancer	Malignant Melanoma	Non-Melanoma Skin Cancer	Other Cancer	Ovarian Cancer
Prostate Cancer	Skin Disease	Von Willebrand		