PLEASE WRITE CLEARLY! DATE: ___________________________

PATIENT'S FIRST NAME: ____________________ MIDDLE INITIAL: _____ LAST NAME: __________________________

SEX: _____ DOB: ______________ SOCIAL SECURITY: ______________________ DRIVERS LICENSE #: _____________

ADDRESS: ____

CITY: ______________________________ STATE: _____ ZIP CODE: ________________

HOME PHONE: ____________________ WORK PHONE: ____________________ CELL PHONE: _________________

E-MAIL ADDRESS: ___________________________________

Are you interested in receiving information on new information and discounts? Yes No

OCCUPATION: Advertising/Agriculture/Architecture/Art & Entertainment/Aviation/Childcare/Construction & Maintenance/Education/Engineering/Financial service/Executive/Healthcare/Human Resources/ Insurance/Internet/Law/Law Enforcement/Marketing/Real Estate /Retail/ Telecommunications/ OTHER: _______________________________

EMPLOYED BY: ____

EMPLOYER'S ADDRESS: ____

NAME OF SPOUSE: ____

SPOUSE BIRTH DATE: ___________________

SPOUSE EMPLOYED BY: ____

EMPLOYER'S ADDRESS: ____

WORK PHONE NO.: ______________________

REFERRED BY: ____

NAME AND ADDRESS OF CLOSEST RELATIVE (IN CASE OF EMERGENCY)

NAME: ______________________________ RELATIONSHIP TO PATIENT: ____

ADDRESS: ____ PHONE NO.: _____________________________________

PLEASE LIST ALL INSURANCE INFORMATION COMPLETELY

DO YOU HAVE MEDICARE: __________ POLICY NO.: _________________________

DO YOU HAVE MEDI-CAL: __________ POLICY NO.: _________________________

NAME OF INSURANCE COMPANY: _______________________________________ (If cash patient, please write "**CASH**")

NAME OF POLICY HOLDER: ____

POLICY HOLDER'S DATE OF BIRTH: ____________________________________

RELATIONSHIP TO THE INSURED: ______________________________________

SUBSCRIBER OR ID NO.: ____

GROUP NO.:____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO ABOVE NAMED PHYSICIAN OF THE SURGICAL AND /OR MEDICAL BENEFITS , IF ANY. OTHERWISE PAYABLE TO ME FOR HIS SERVICES AS DESCRIBED ON ATTACHED CLAIM.

X SIGN:_____________________________________ DATE: __________________________

PAYMENT OF SERVICES:

I REALIZE THAT THIS MAY NOT REPRESENT THE FULL PAYMENT FOR SERVICES RENDERED AND I WILL BE RESPONSIBLE FOR THE BALANCE DUE.

X SIGN: ____________________________________ DATE: ___________________________

AUTHORIZATION TO RELEASE INFORMATION:

I HEREBY AUTHORIZE ABOVE NAMED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

SIGN:_____________________________________ DATE: __________________________

Douglas Hamilton, M.D.

Diplomate, American Board of Dermatology

Shanah Gavia, MPA-C

450 N. Bedford Drive, Ste 111
Beverly Hills, CA 90210
(310) 271-6663

6325 Topanga Canyon Blvd, Ste 301
Woodland Hills, CA 91367
(818) 884-7150

DERMATOLOGY PATIENT QUESTIONAIRE

PLEASE PRINT IN INK

Name: ___________________________________ Age: ______ Referred By: ______________________ Date: ________________

Please answer the following questions as completely as possible. If you have any problems understanding the questions please ask the receptionist.. If you have any further comments please bring them to the attention of Dr. Hamilton.

BEGINNING

Where on your skin/body did your problem begin? ____

When did it begin (approximately what date)? ____

What did it look like when it began (color, approximate size, and was it solid or filled with fluid)? ____________________________________

CHANGES

When did it begin to change? ____

Where on your skin/body did the condition involve next? ____

Where does it involve now? ____

What changes, if any, did it undergo (in color, size, or consistently)? ____

AFFECTING FACTORS

What makes it better? ____

What things, if any, do you think might have brought on your skin problem? ____

What treatment have you had for this condition (physician or home remedies)? ____

SYMPTOMS

Does it itch? YES / NO ____

Is it painful? YES / NO ____

FAST DERMATOLOGICAL HISTORY

What skin problems have you had in the past? ____

Have you had hay fever or Asthma? ____

MEDICATIONS

What medications do you take (include medicine as any substance which you take by mouth other than food)? ____________________________

What medicines are you allergic to (if any)? ____

FAMILY HISTORY

Identify the relation (e.g., mother, father, etc.) of any blood relative who have diabetes mellitus (“sugar blood”) or tuberculosis (“T.B.”):
____

What other skin diseases have you had in your family (and their relation to you)? ____

SOCIAL HISTORY

What is your occupation?: ____

Do you come into contact with any chemicals on the job or in a hobby (if so, what?)?: ____

REVIEW OF SYSTEMS

What other health problems do you have?: ____

PAST MEDICAL HISTORY

Have you ever had any of the following diseases (*please circle):* cataracts or glaucoma of the eye, diabetes mellitus, tuberculosis, high blood pressure, peptic ulcer (stomach or intestine) or bleeding problems

List all dates (approximate year) of hospitalizations & diagnosis (if known): ____
____
____

Douglas Hamilton, M.D.

Assistant Clinical Professor UCLA School of Medicine
Diplomate of American Board of Dermatology
Dermasurgery

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Notice of Privacy Practices Patient Acknowledgement

Patient Name: ____

Date of Birth: _______________________

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice.

I understand I can obtain this practice's current Notice of Privacy Practices upon request or download them at any time from the practice website: douglashamiltonmd.com.

Signature: ____

Date: _______________________

Relationship to patient (if signed by a personal representative of patient):

____