



<b>PATIENT INFORMATION</b>				
Patient's Last Name:		First Name:		Middle Initial:
Mailing Address:			City:	State: Zip:
Email address:			Would you like to receive emails on our current specials? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Home Phone: ( )		Mobile Phone: ( )		Work Phone and Extension: ( )
Patient DOB:	Age:	Sex:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other	
Ethnicity: <input type="checkbox"/> Hispanic / Latin <input type="checkbox"/> Not Hispanic or Latin <input type="checkbox"/> Decline to State		Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian / Other Pacific <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Other Race <input type="checkbox"/> Decline to State		
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Other: _____		Social Security Number:	Occupation:	
Primary Care Physician and Phone:			Referring Provider and Phone:	
How Did You Hear About Our Office?				
<b>IN CASE OF EMERGENCY</b>				
Name of Emergency Contact Person:		Relationship to Patient	Home Phone: ( )	Cell Phone: ( )
<b>RESPONSIBLE PARTY (GUARANTOR) (if patient is spouse, dependent, or student)</b>				
Guarantor's Last Name:		Guarantor's First Name:		Guarantor's Middle Name:
Mailing Address:			City:	State: Zip:
Guarantor's DOB:	Relationship to Patient:		Home Phone: ( )	Cell Phone: ( )
<b>PRIMARY INSURANCE (please present new insurance card to our office staff)</b>				
<input type="checkbox"/> Self-Pay / No Insurance <input type="checkbox"/> Patient is the Insured Subscriber		Policy Subscriber's Name (if not patient):		Policy Subscriber's DOB (if not patient):
Name of Primary Insurance:		Primary Insurance Address:		Policy Subscriber's Phone: ( )
Patient's Relation to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other, please specify:			Policy Subscriber's Social Security #:	
Subscriber Number:		Group Number:		Specialist Co-Pay: \$
<b>SECONDARY INSURANCE (please present new insurance card to our office staff)</b>				
<input type="checkbox"/> Self-Pay / No Insurance <input type="checkbox"/> Patient is the Insured Subscriber		Policy Subscriber's Name (if not patient):		Policy Subscriber's DOB (if not patient):
Name of Secondary Insurance:		Secondary Insurance Address:		Policy Subscriber's Phone: ( )
Patient's Relation to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other, please specify:			Policy Subscriber's Social Security #:	
Subscriber Number:		Group Number:		Specialist Co-Pay: \$
<b>PHARMACY INFORMATION</b>				
Pharmacy Name:		Pharmacy Location (address or intersection is okay):		Pharmacy Phone: ( )

**Please continue onto back....**

**Please list any medications you are currently taking:**

Name	Dose	Name	Dose
1)		4)	
2)		5)	
3)		6)	

**If you are allergic to any medications, please list below:**

Name	Reaction Type	Name	Reaction Type
1)		3)	
2)		4)	

**Please list any major surgeries and/or hospitalizations:**

1)	Date:	3)	Date:
2)	Date:	4)	Date:

**Do you have now, or have you ever had diseases or conditions of: (Please circle all that apply)**

Anxiety	Colon Cancer	Hearing Loss	Leukemia
Arthritis	COPD	Hepatitis	Lung Cancer
Asthma	Coronary Artery Disease	Hypertension	Lymphoma
Atrial Fibrillation	Depression	HIV/AIDS	Prostate Cancer
Bone Marrow Transplant	Diabetes	Hypercholesterolemia	Radiation Treatment
BHP	End Stage Renal Disease	Hyperthyroidism	Seizures
Breast Cancer	GERD (Acid Reflux)	Hypothyroidism	Stroke

**Do you have any of the following skin conditions? (Please circle all that apply)**

Acne	Dry Skin	Melanoma	Psoriasis
Actinic Keratosis	Eczema	Poison Ivy	Squamous Cell Skin Cancer
Basal Cell Skin Cancer	Flaking or Itchy Scalp	Precancerous Moles	Other: _____
Blistering Sunburns	Hay Fever/ Allergies		

**Social History:**

Have you received the flu vaccine in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you received the pneumonia vaccine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear sunscreen? If yes, SPF _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use tanning beds?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you smoke?	<input type="checkbox"/> Never <input type="checkbox"/> Former Smoker <input type="checkbox"/> Current Smoker
Do you drink alcohol? If yes _____ drinks per day	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you drink caffeine? If yes _____ cups per day	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you exercise?	<input type="checkbox"/> Never <input type="checkbox"/> Daily <input type="checkbox"/> Weekly

**Please list any relatives that have had any of the following:**

Disease	Relative	Disease	Relative
Autoimmune Disease	_____	Elevated Cholesterol	_____
Cancer	_____	Melanoma	_____
Diabetes	_____	Psoriasis	_____
Eczema	_____	Skin Cancer	_____

**Financial Policy – All Patients, Including Medicare**

Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments will be collected. The patient is responsible for any/all charges not paid for by their insurance company. I agree, either as an agent or as the patient, that I am obligated to pay any/all fees for the exam that may not be covered or authorized by my insurance carrier.

**Financial Policy – Medicare Patients Only**

I authorize any holder of medical records or other information about me to release to the Social Security Administration and Center for Medicare Services, or its intermediaries or carrier, any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. This authorization is valid until revoked in writing.

**No-Show & Cancellation Policy**

Appointment times at Torrey Pines Dermatology are scheduled to allow us to give proper care to each individual patient’s needs during the patient’s visit. We value advance notice from our patients who are unable to attend their scheduled appointments in order to open appointments for patients on our waiting list. To promote efficient access to Torrey Pines Dermatology, we maintain a No Show/Cancellation policy to all our patients. We require appointments to be cancelled 24 business hours before the scheduled appointment. Cancellations must be made during our business hours of 8 a.m. and 4:30 p.m. by phone at (858) 362-8800.

In the event that an appointment is missed or cancelled with less than a 24-hour notice or no notice at all, a **\$100 non-insurance charge** will be billed to the patient. If the patient is cosmetic and has a package of cosmetic treatments, **one treatment will be removed** from the package.

This policy is in effect for all patient appointments at our practice, including clinical research, and cosmetic appointments.

*I understand that I will be charged a \$100 fee if I do not call to cancel an appointment within 24 hours of the scheduled appointment time.*

**Privacy Practices (HIPAA)**

**Receipt of Privacy Practices:** You have a right to obtain a paper copy of this notice upon request.

**Contact Information:** You have the right to request Torrey Pines Dermatology to communicate with you using a preferred method.

**If you are over 18 years old, do we have permission to speak to a designated person about your care?**

**If yes, Please list any persons to whom your protected health information CAN be disclosed**

**(e.g. spouse, parent, caregiver, etc.):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

*My signature below acknowledges that I have read, understood, and agreed to all the above Torrey Pines Dermatology Policies.*

**Please Print Patient’s Name:** \_\_\_\_\_

**Patient/Responsible Party Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_