TORREY PINES DERMATOLOGY

Please Write Legibly

PATIENT INFORMATION

(as it appears on primary insurance card)

First Name:	Last Name:	Middle Initial:

Social Security #: (if TPD is billing insurance only)	Date of birth:	□ Female □ Male	Marital Status: □ Single □ Married □ Widowed

Employment Status: □ Employed □ Retired □ Student Referred By: □ Family/Friend □ Google □ Physician □ Previous Patient □ Other	Mailing Address: City/State/Zip

Consent to Email: □Yes □ No	Email:	Best Ph #: ( )

IN CASE OF EMERGENCY

First Name:	Last Name:	Relation to Patient:	Best Ph#: ( )

PHYSICIAN's INFORMATION

Primary Care Physician's Full Name:	Office#: ( )
Referring Physician's Full Name:	Office#: ( )

RESPONSIBLE PARTY

complete if minor only (17 or younger)

First Name:	Last Name:	Middle Name:

Mailing Address: (if different than above)	City:	State:	Zip:

Date of birth:	Relation to Patient:	Best Contact #: ( )	Other Phone #: ( )

□ *Check Box if Self Pay*

PRIMARY INSURANCE

(please present insurance(s) card)

Insurance Name:	Id#:	Group#:

Card Holder's Name:	Dob:	□ Male □ Female

Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other (please specify)	Social Security #:

SECONDARY INSURANCE

Insurance Name:	Id#	Group#:

Card Holder's Name:	Dob:	□ Male □ Female

Relation to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other (please specify)	Social Security #:

You may write on back of this page if necessary…

Signature:____ Date:_____/______/2020

Patient Name: ________________________________ **dob:** ______________

Pharmacy Name & Location:

Basic Medical Info: Height_____ weight_______ Flu vaccine this year: **Yes/No** Pneumonia Vaccine: **Yes/No**

PAST MEDICAL HISTORY (circle): NONE □

anxiety
arthritis
asthma
atrial fibrillation
bone marrow transplant
BHP
breast cancer
colon cancer
COPD
coronary artery disease
depression
diabetes
end stage renal disease
GERD (acid reflux)
hearing loss
hepatitis
hypertension
HIV/AIDS
hypercholesterolemia
hyperthyroidism (high)
hypothyroidism (low)
leukemia
lung cancer
lymphoma
prostate cancer
radiation treatment
seizures
stroke

LIST ANY MAJOR SURGERIES & HOSPITALIZATIONS: NONE □

1)______________________ Date: **3)**______________________ Date:

2)______________________ Date: **4)**______________________ Date:

PAST SKIN CONDITIONS (circle): NONE □

acne
actinic keratoses
basal cell skin cancer
blistering sunburns
dry skin
eczema
flacking or itchy scalp
hay fever/allergies
melanoma
poison ivy
precancerous moles
psoriasis
squamous cell skin cancer

Do you wear sunscreen?..if yes, what SPF? __________ □ Yes □ No
Do you tan in a tanning salon? □ Yes □ No
Do you have a family history of melanoma? □ Yes □ No
If yes, which relative? □ None □ Mother □ Father □ Sister □ Brother □ Daughter □ Son □ Uncle □ Aunt □ Nephew □ Niece □ Grandmother □ Grandfather □ Grandson □ Granddaughter □ Other ___________

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: (include OTC)

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

□ **No Known Drug Allergies** **LIST ALL MEDICATIONS ALLERGIC TO:**

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

SOCIAL HISTORY:

Do you smoke? □ Never □ Former Smoker □ Current Smoker (circle: Tobacco or Cigar)
#____ of packs per day # ____ total of years smoking
Do you drink alcohol? If yes #_____ of drinks per day
Do you drink caffeine? If yes #_____cups per day
Do you exercise? □ Never □ Daily □ Weekly

Occupation___________________
Advanced care plan: **Yes/No**
Designee name______________________
phone______________________

FAMILY HISTORY:

Mother: □Autoimmune Disease □Cancer □Diabetes □Eczema □High Cholesterol □Melanoma □Psoriasis
Father: □Autoimmune Disease □Cancer □Diabetes □Eczema □High Cholesterol □Melanoma □Psoriasis
Sibling#1: □Autoimmune Disease □Cancer □Diabetes □Eczema □High Cholesterol □Melanoma □Psoriasis
Sibling#2: □Autoimmune Disease □Cancer □Diabetes □Eczema □High Cholesterol □Melanoma □Psoriasis

OFFICE POLICY

My initials below represent that I have read and understood the following policies:

Assignment of Benefits & Financial Policy – all patients

Copays, deductibles, coinsurance and non-covered services due to not medically necessary are patient's responsibility. TPD will collect the copay at time of service and bill your insurance as a courtesy. Ultimately, patient is responsible for coordination of benefits and understanding their insurance plan for In or Out of Network benefits. You authorize to pay any/all fees for the exam/treatment and any services rendered at TPD. **Initials: ______**

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. **Initials: _____**

No-Show & Cancellation Policy

In the event that an appointment is missed or cancelled with less than a 24-hour notice or with no notice at all, *$100 charge will be assessed to the patient's account.* We schedule allotted appointments which allows us to give proper care to each individual's needs. We value an advance notice if unable to show for appointment time so that we can offer this appointment to other patients who are on our waiting list. Cancellations must be made during our business hours of 8 a.m. and 4:30 p.m. by phone at (858) 362-8800. **Initials: _____**

Cosmetic Policy

If you have scheduled a cosmetic procedure including neurotoxin (Botox, Dysport, Jeuveau), fillers, or single laser treatment (does not include Active FX, Deep FX, or Ultherapy) a $200 fee will be assessed if the appointment is cancelled within 24 hours of the scheduled time. If you have purchased a series of treatments, one treatment will be removed from the package in replacement of the $200 fee. For any Active FX, Deep FX, or Ultherapy at the time of booking there is a 50% nonrefundable deposit required at booking. **Initials**: _____

HIPAA Privacy Practices

TPD values your privacy and protects your personal information from anyone outside the practice without your permission unless it's related to insurance, referring providers or other TPD affiliations for lab services, referrals, etc. Our HIPAA manual is available for you to read so that you better understand how TPD must protect your personal data. Please ask the front desk for the manual if you choose to read or request a copy. **Initials: _____**

Lab Affiliation (UCSF)

TPD uses UCSF (University of San Francisco) for outside lab facility. It is patient's responsibility to inform the medical assistant that there is a preferred lab per their insurance in order to avoid billing errors and receive a lab order instead. Initials: _____

By my signature below acknowledges that I agree to the terms and conditions above regarding Torrey Pines Dermatology Policies.

Print Patient Name: ____

Signature of Patient/Guardian: _______________________________________ Date: ___/___/2020

E-MAIL CONSENT

Decline:

Initial _____ I decline for the use of any email communication.

Authorize:

Initial ____ I authorize any email communication.

I am: ______a) An established patient of Torrey Pines Dermatology (TPD)

______b) The guarantor of an established patient.

The authorized use to communicate to this email address(es):

E: ______________________________________@_________________________________

I may want to communicate with the TPD providers and staff by e-mail.

I understand the risks of communication by email, in particular, the privacy risks explained in this form.

I understand that TPD cannot guarantee the security and confidentiality of e-mail communication. The physicians, staff, and TPD will not be responsible for messages that are not received or delivered due to technical failure or for disclosure of confidential information unless caused by intentional misconduct.

I understand that I may also communicate with TPD by telephone or during a scheduled appointment, and that email is not a substitute for care that may be provided during an office visit. Appointments should be made to discuss any new or complex issues.

I understand that I may stop using e-mail as a means of communication upon my written request.

I understand that I may revoke this consent at any time by advising TPD in writing. My revocation of consent will not affect my ability to obtain future health care, nor will it cause the loss of any benefits to which I am otherwise entitled.

I have read and understand this form. I have had the opportunity to ask questions, and my questions have been answered to my satisfaction. I understand and agree with the information contained in this form and give my consent for e-mail communications to and from TPD.

Print Patient Name: ____

Signature of Patient/Guardian: ____Date: _____/____/ 2020

TORREY PINES
DERMATOLOGY

PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

I consent for medical photographs to be made of me or my child (or the person for who I am legal guardian). I understand that the information may be used in my medical record for purpose of medical teaching or for publication in medical textbooks or journals as I have designated below. By consenting to these medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care you will receive. If I have questions or wish to withdraw my consent in the future I may contact:

Kristen A. Richards, MD./P: 858.623.8800/E: admin@torreypines.com/Address: 9850 Genesee Ave Ste 460 La Jolla CA 92037

By signing this form below I confirm that this consent form has been explained to me in terms which I understand:

1. I consent for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

   ______________________________________ ______________________________________
   Signature Witness

2. I agree for my image to be shown for teaching purposes **AND** to be used for my medical record but **NOT FOR** medical publications.

   ______________________________________ ______________________________________
   Signature Witness

3. I agree to the use of my image for medical records **ONLY**.

   ______________________________________ ______________________________________
   Signature Witness

For patients between ages 7 and 18 years, a signature below indicates that the information in this consent form has been explained to me, and I assent to use of my images as outlined above:

1.

   ______________________________________ ______________________________________
   Signature Witness

   DATE: _____/______/2020

TORREY PINES
DERMATOLOGY

PATIENT COMMUNICATION FORM

A. Family & Friends. It is the office policy of Torrey Pines Dermatology not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other 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, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse: ____ __________ yes __________ no

Parent: ____ __________ yes __________ no

Other: ____ __________ yes __________ no

B. Message Consent. I understand that my healthcare information is protected. I understand that, in order for us to leave a detailed message on my voicemail or answering machine, I need to give my permission.

Consent to leave a detailed message: □Yes □No

Consent to leave lab result information on voicemail: □Yes □No

Consent to leave biopsy results on voicemail: □Yes □No

If yes, best phone number: __________________________

Print Patient Name: ____

Patient Signature:____

Date:_____/______/_____