

Please Write Legibly

PATIENT INFORMATION					
<i>(as it appears on primary insurance card)</i>					
First Name:		Last Name:		Middle Initial:	
Social Security #: (if TPD is billing insurance only)		Date of birth:	<input type="checkbox"/> Female <input type="checkbox"/> Male	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed	
Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Retired <input type="checkbox"/> Student		Mailing Address:			
Referred By: <input type="checkbox"/> Family/Friend <input type="checkbox"/> Google <input type="checkbox"/> Physician <input type="checkbox"/> Previous Patient <input type="checkbox"/> Other		City/State/Zip			
Consent to Email: <input type="checkbox"/> Yes <input type="checkbox"/> 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					
<i>complete if minor only (17 or younger)</i>					
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 #: ()	
PRIMARY INSURANCE					
<input type="checkbox"/> <i>Check Box if Self Pay</i>					
<i>(please present insurance(s) card)</i>					
Insurance Name:		Id#:		Group#:	
Card Holder's Name:			Dob:	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Relation to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (please specify)			Social Security #:		
SECONDARY INSURANCE					
Insurance Name:		Id#:		Group#:	
Card Holder's Name:			Dob:	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Relation to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (please specify)			Social Security #:		

You may write on back of this page if necessary...

Signature: _____ Date: ____/____/____

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 | 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 (high) | seizures |
| breast cancer | GERD (acid reflux) | hypothyroidism (low) | stroke |

LIST ANY MAJOR SURGERIES & HOSPITALIZATIONS: NONE

- 1) _____ Date: _____ 3) _____ Date: _____
 2) _____ Date: _____ 4) _____ Date: _____

PAST SKIN CONDITIONS (circle): NONE

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

- 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 Occupation _____
 Do you drink alcohol? If yes # _____ of drinks per day Advanced care plan: **Yes/No**
 Do you drink caffeine? If yes # _____ cups per day Designee name _____
 Do you exercise? Never Daily Weekly 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: ___/___/___

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@torreypinesderm.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: ____/____/____

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: ____/____/____