TORREY PINES
DERMATOLOGY & LASER CENTER

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 How did you hear about us? □ 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#: ( ) Fax# ( )
Referring Physician's Full Name: Office#: ( ) Fax# ( )

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 the back of this page if necessary…

Pharmacy Name & Location:

Height_____ weight_____ Flu vaccine this year: **Yes/No** Pneumonia Vaccine: **Yes/No** Covid 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	flaking 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) Height_____ Weight_____
#____ of packs per day # ____ total of years smoking
Do you have any food/transportation insecurity?: **Yes/No**
Advanced care plan: **Yes/No** Living Will: **Yes/No**
Person designated to make health care decisions for you if you are unable: 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

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OFFICE POLICY

Assignment of Benefits & Financial Policy – all patients

Copays, deductibles, coinsurance and non-covered services due to not medically necessary are your responsibility. TPD will collect the copay and a portion of your outstanding deductible at time of service and bill your insurance as a courtesy. If a referral or an authorization is required by your insurance, it is your responsibility to make sure one has been issued prior to your visit. Ultimately, the patient is responsible for coordination of benefits and understanding their insurance plan for In or Out of Network benefits. You are responsible for paying any/all fees for the exam/treatment and any services rendered at TPD.

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 the assignment. Regulations pertaining to Medicare assignment of benefits apply. This authorization is valid until revoked in writing.

No-Show & Cancellation Policy

In the event that an appointment is missed or canceled with less than a 24-hour notice or with no notice at all, *a $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.

CREDIT CARD ON FILE

To Hold your appointment, we require a credit card on file to be held for copays and cancellations. If you miss or cancel with less than a 24-hour notice or with no notice at all, we will charge your card on file for a $100 fee.

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 $100 fee will be assessed if the appointment is canceled within less than 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% non refundable deposit required at booking.

HIPAA Privacy Practices

TPD values your privacy and protects your personal information from anyone outside the practice without your permission unless it is 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.

Lab Affiliation (UCSF)

TPD uses UCSF (University of San Francisco) for outside lab facility. It is the 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.

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 whom I am legal guardian). I understand that the information may be used in my medical record for the 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: 858.362.8800/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: **You must select one of the 3**

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

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:_____/_____/_____

Effective 01/01/2021