PATIENT INFORMATION

Today's date: _____ Appointment with Doctor: _____

Last name: _____First:_____Middle:_____

Marital status: Married/Single/Divorced/Other Last 4 digits of SSN: _____ Gender: M/F Birthdate: ___/___/___

Home Address: _____City_____State _____ Zip_____

Home Phone: _____Cell _____ Work _____

Occupation : _____

Primary Language: __English __Arabic __French__German__Mandarin__Spanish__Russian__Other

Race : __American Indian __Asian __African American or Black __White __Unknown

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Primary Pharmacy: _____Address: _____Phone:_____

Referring Doctor:_____ Other : _____

Email Address: _____@_____ Driver's License No#: _____State _____

Best contact: □ Home □ Work □ Cell May we leave a message? □ Voicemail □ Person

Individuals with whom we may discuss your medical information: _____

Emergency Contact Name & Phone Number: _____

Reason For Today's Visit

Concern: **Location:** **Duration:**

CRITICAL/PAST MEDICAL HISTORY

Anticoagulant treatment	□ Yes □ No	Diabetes	□ yes □ No
Bleeding Disorders	□ Yes □ No	Eczema	□ yes □ No
MRSA	□ Yes □ No	HSV/cold sore	□ yes □ No
Pacemaker/defibrillator	□ Yes □ No	Psoriasis	□ yes □ No
Melanoma	□ Yes □ No	HIV	□ yes □ No
Other Skin Cancers	□ Yes □ No	Hepatitis C	□ yes □ No

FAMILY MELANOMA HISTORY

Do you have a family history of melanoma? ____ Yes ____No Who:_____

Do you have a family history of other skin cancer(s)? ____ Yes ____No Who: _____

SOCIAL HISTORY

Do you use tobacco? □ Current □ Former □ Never

Alcohol consumption? □ Never □ Daily □ Weekly □ Monthly

Do you use sunscreen? □ None □ Daily □ Occasionally

Tanning bed use? □ None □ Current □ Previous

Date of last Flu Shot _____ Date of Pneumonia Shot _____

FOR WOMEN ONLY

Are you pregnant? □ yes □ No

Are you breastfeeding? □ yes □ No

Are you on birth control? □ yes □ No

Do you have regular menstrual cycles? □ yes □ No

CURRENT MEDICATIONS

□ None

Medication: _____Dose: _____ Medication:_____Dose: _____

Medication: _____Dose: _____ Medication:_____Dose: _____

Medication: _____Dose: _____ Medication:_____Dose: _____

Medication: _____Dose: _____ Medication:_____Dose: _____

MEDICATION ALLERGIES

Do you have any medication allergies? _____

FINANCIAL INFORMATION

Person Responsible for payment: _____ Relationship: _____

Address: _____City_____State_____Zip _____

Phone: **Home** _____ **Work** _____ **Cell** _____

SSN: _____-_____-_____ Date of Birth: _____ Occupation: _____

Business Address: _____City _____State_____Zip_____

INSURANCE INFORMATION

Primary Insurance: _____Relationship to Patient _____

Subscribers Name: _____ Date of Birth: _____

CONSENT FOR TREATMENT

By signing this form, you consent to our disclosure of protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy provides more detailed information about how we may use and disclose this protected health information. You have legal right to review our Notice of Privacy Practices before you sign this consent and we encourage you to read it in full. Your signature indicates you understand and acknowledged the notice of privacy Practices. The Notice of Privacy Practices is subject to change. You may obtain a copy of the revised notice by contacting David A. Denenholz, M.D., Inc. @ (626) 449-4207.

FINANCIAL STATEMENT

By signing this form, you are accepting direct responsibility for all financial obligations to David A. Denenholz, M.D. ,Inc. for services rendered by this office. Payment is expected at the time of service or upon receipt of the statement (for charges due after insurance). Financial obligations include deductibles, coinsurance, charges not covered such as immunizations, cosmetic procedures, and other charges not deemed medically necessary by your insurance company. It is your responsibility to verify if the doctor is contracted with your insurance company and to pay the charges in full. Some laboratory/pathology and second opinion charges are billed directly by the laboratory/doctor. A $5.00 per month service charge will be added to overdue balance and service charge of $25 will be added on returned checks. This assignment remains in effect until revoked in writing. A copy of the paper shall be as valid as the original. Your signature below indicates that you understand and accept this policy.

Cancellation & "No Show" Fee Policy. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Pasadena Premier Dermatology reserves the right to charge a fee of $35.00 for all missed appointments ("No Show") and appointments which, are not cancelled with a 24-hour advance notice.

Patients Signature: _____ Date: _____

Please provide a current copy of your Insurance card and your Driver's License to the Receptionist.