CENTER FOR DERMATOLOGY COSMETIC & LASER SURGERY

Patient Information as of _____ (enter today's date)

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Pt. Acct. # _____

Any restrictions for contacting you? ☐ No ☐ Yes E-mail _____

Email/Other Restrictions: _____ Pharmacy Name & street,City _____

Age _____ Birth Date _____ SS# _____ Sex ☐ Female ☐ Male

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ☐ Yes ☐ No

Emergency Contact _____ Relationship to Patient _____

Home Phone _____ Other Phone _____

Primary Insurance Co. & Address _____

Ins. ID# _____ Group # _____ SS# _____

Referral Required? ☐ No ☐ Yes Copay$: _____ Coins % : _____ Eff. _____

Insured: Name _____ DOB _____ Employer _____

Secondary Insurance Co. & Address _____

Ins.ID # _____ Group # _____ SS# _____

Referral Required? ☐ No ☐ Yes Copay$ _____ Coins % : _____ Eff. Date _____

Insured: Name _____ DOB _____ Employer _____

If Patient is a Minor or Student

MothersName_____ DOB_____SSN#_____Home Phone_____
HomeAddress_____
Occupation_____Employer_____Work Phone_____
FathersName_____DOB_____SSN#_____Home Phone_____
HomeAddress_____
Occupation_____Employer_____Work_____
Phone_____

Please Note If there is any question regarding this bill, the person who is registering today will be responsible for payment. If patient is a minor the person registering for the patient will be responsible. Should claim be denied due to patients unwillingness to supply necessary information, patient acknowledges financial responsibility.

Release Statement I authorize the Center to perform diagnostic tests and provide treatment necessary for medical evaluation and health care for above mentioned patient. I also authorize release of information to my insurance company. I accept responsibility for all charges incurred in the medical evaluation and health care of the above named patient. I understand that ongoing primary medical care is the responsibility of the referring physician or another physician of my choice; it is not the responsibility of the Center. If a copay or deductible is required on your insurance **it must be paid at time of visit.** A $10.00 billing fee will be charged if you are seen and unable to pay at that time. **WE REQUIRE 24 HOURS NOTICE OF CANCELLATION. THERE IS A CHARGE OF $50.00 FOR AN APPOINTMENT NOT KEPT ($75.00 for Saturdays appts, 48 hr notice needed).**_____**PLEASE INITIAL**

Authorization for automated Credit Card Payment. I authorize my credit card # to be on file with The Center for Dermatology to use for automatic payment of any balance owing/due to the Center for Dermatology which is less than $100.00. (A statement will be sent to my address showing payment transaction). _____**PLEASE INITIAL.** For any reason, I am able to recind this agreement at anytime upon Center for Dermatology receiving a written request.

REFERRING DOCTOR _____

SIGNATURE_____**DATE**_____

Race: **Ethnicity**: **Language**:

Appointment Policy for Teledermatology

If scheduling a Teledermatology appointment with a Provider, an extended amount of appointment time has been reserved for you. If for any reason you feel the need to cancel and/or reschedule the appointment, you will need to provide us at least 24-hour notice. If you do not keep your appointment, cancel, or reschedule less than 24 hours in advance, then there will be a charge of $100.00 to your account. If your Teledermatology appointment is scheduled on a Monday, you will need to contact us by Friday 12:30 pm at the latest.

Last minute cancellations or non-kept patient appointments impact the delivery of services to our patients. Center for Dermatology has been forced to implement this policy in an effort to enhance the availability of our providers and to deliver timely care to ALL our patients. If you do not cancel in a timely manner, other patients, who are waiting to be seen, are deprived of that opportunity. Your cooperation and adherence to the 24-hour notice of cancellation policy is greatly appreciated.

If you have a Teledermatology appointment scheduled, it is the patient's responsibility to contact their insurance and confirm this is a covered benefit under their plan. By signing this consent, you are in agreement that if this consult is not a covered benefit under your plan you are responsible for all acquired fees. Our office will check patient's eligibility in a timely manner before the appointment date and time; however, verifying eligibility does not guarantee benefit coverage.

All copays/deductibles will be collected 30 minutes before the appointment time. Once payment has be received our office will email/text you the link for your Teledermatology appointment with your selected provider.

Thank you for your understanding and cooperation.

Patient Signature:_____ Date:_____

Acknowledgement of Receipt of Notice

CENTER FOR DERMATOLOGY COSMETIC AND LASER SURGERY

2557 MOWRY AVENUE, STE 25&34
FREMONT, CA 94538
(510) 797-4111

995 MONTAGUE EXPWY, STE. 111
MILPITAS, CA 95035
(408) 957-7676

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Yes No (circle one) I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: _____.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the patient:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: _____

For Office Use Only:

- ☐ Signed form received by: _____
- ☐ Acknowledgment refused:

Efforts to obtain:

_____

_____

Reasons for refusal:

_____

Appointment Policy for Procedures/Surgery with a Provider

If scheduling a procedure, surgery, or laser procedure with a Provider, an extended amount of appointment time has been reserved for you. If for **any reason** you feel the need to cancel and/or reschedule the appointment, you will need to provide us **at least 72 hour notice.** If you do not keep your appointment, cancel, or reschedule less than 72 hour in advance; then there will be a **charge of $150.00** to your account. If you would like to reschedule the missed/rescheduled appointment we will require a **deposit of $150.00 due upon scheduling** which is non-refundable and will be applied to your procedure. If your procedure is scheduled on a Monday, you will need to contact us by Thursday 12:30 pm at the latest.

Appointment Policy for Cosmetic Laser Treatment with a Registered Laser Nurse

If for **any reason** you feel the need to cancel and/or reschedule a cosmetic laser appointment, you will need to provide us **at least 72 hour notice.** If you do not keep your appointment, cancel, or reschedule in advance; then there will be a **charge** to your account which will result in deducting from your prepayment. **Cosmetic services are not covered by insurance companies, and for this reason the following policy is necessary:**

- The fees for your selected **Laser** procedures must be made in **cash** or a **cash equivalent** (money order or credit card) Payment is **due at the time of scheduling.**

- No appointment will be made unless the payment has been received in full. If, **prior to your Appointment, you find it necessary to cancel or reschedule your Cosmetic laser treatment with the Laser Nurse for any reason, the following refund will be made:**
  1 week or more =100%, 48 hours to less than 1 week=50%, Less than 48 hours= 0%.
- **Patients that wish to cancel their Laser Packages after a few treatments will be charged a cancellation fee of $250.00.**

Last minute cancellations or non-kept patient appointments impact the delivery of services to our patients. Center for Dermatology has been forced to implement this policy in an effort to enhance the availability of our providers and to deliver timely care to ALL our patients. If you do not cancel in a timely manner, other patients, who are waiting to be seen, are deprived of that opportunity. Your cooperation and adherence to the **72-hour notice of cancellation policy** is greatly appreciated.

Thank you for your understanding and cooperation.

Patient Signature:_____ Date:_____

CENTER FOR DERMATOLOGY COSMETIC AND LASER SURGERY

Patient info as of 2/19/2021

MEDICARE REGISTRATION

PATIENT'S NAME _____
First Middle Last

Address _____
Street& Apt#/Unit City State Zip

Home Phone _____ Cell Phone _____ Acc# _____

Any restrictions for contacting you? Yes ☐ No ☐ E-mail _____

Contact Restrictions: _____ Pharmacy Name & street,city _____

Age _____ Birth Date _____ SS# _____ Sex : Female/Male _____

PATIENT'S EMPLOYER _____ Work Phone _____

Is it okay to call you at work? Yes No

Address _____
Street & Apt#/Unit City State Zip

EMERGENCY CONTACT _____ **Relationship to Patient:** _____

Home Phone _____ Other Phone _____

MEDICARE INSURANCE INFORMATION _____

SS#/ID# _____ Eff. Date _____

Insured : Name _____ DOB _____ SS# _____

SECONDARY INSURANCE COMPANY _____

Ins. ID # _____ Group # _____

Co-pay _____ Eff. Date _____

Referral Required? Yes ☐ No ☐ Employer _____

INSURED Name _____ DOB _____ SS# _____

2/20/2021 7:15 AM **Race: Ethnicity: Language**:

Please answer Yes/No to the questions below

YES	NO	
☐	☐	Have you recently joined a Medicare HMO? If yes, identify _____
☐	☐	Do you or your spouse work in a company which has more than 20 employees and have insurance at that job?
☐	☐	Are you covered by an HMO/PPO insurance that makes Medicare secondary?
☐	☐	Is this illness covered by the Veterans Administration?
☐	☐	Is this illness due to an automobile accident or an injury at work?
☐	☐	Is this illness covered by the Federal Black Lung or End-Stage Renal Disease Program?
☐	☐	Are you receiving Medicaid?

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any needed information for this or a 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 the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature _____ **Date** _____

Referring Doctor _____

Patient's Name: _____ _____

I authorize the Center to perform diagnostic tests and provide treatment necessary for medical evaluation and health care for above named patient. I accept responsibility for all charges incurred in the medical evaluation and health care of the patient named above. I understand that ongoing primary medical care is the responsibility of the referring physician or other physician of my choice; it is not the responsibility of the Center. **If a co-pay or deductible is required on your insurance it must be paid at the time of the visit. A $10.00 billing fee will be charged if you are seen and unable to pay at the time of service. We require 24 hour notice of cancellation. There is a charge of $50.00 for a not kept appointment.** If there is any question regarding this bill, the person who is registering today will be responsible for payment. Should the claim be denied due to patient's unwillingness to supply necessary information, patient acknowledges financial responsibility.

Signature_____**Date**_____

If you have a supplemental policy (secondary insurance to Medicare) to which your Medicare automatically "crosses over", we are required to keep a separate signature on file:

I request authorized supplemental insurance benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above supplemental insurance carrier any information needed to determine these benefits or the benefits payable for related services.

Signature_____**Date**_____

Authorization for automated Credit Card Payment. I authorize my credit card # to be on file with The Center for Dermatology to use for automatic payment of any balance owing/due to the Center for Dermatology which is less than $100.00. (A statement will be sent to my address showing payment transaction). _____**PLEASE INITIAL.** For any reason, I am able to recind this agreement at anytime upon Center for Dermatology receiving a written request.

Welcome to the Center for Dermatology, Cosmetic, and Laser Surgery!

Please take a moment to fill out our new patient form. Thank you!

Name _____ **Date of Birth** _____

Phone # _____ **Alternate Phone #** _____

Height _____ **Weight**_____ **Gender** _____

What is your preferred pharmacy? Please include street/city. _____

In just a few words, what is the reason for your visit today? _____

_____

Do you have any allergies to any medications? Yes ☐ No ☐ If yes, please fill out the following:

Medication	Reaction (i.e. rash, throat swelling, etc.)

What medications do you currently take? Please provide name, dose, and frequency.
Please include any over-the-counter medications and/or supplements you take as well.

Medication Name	Dose	Frequency (i.e. once daily)

Do you have or have you ever had any diseases of:

	Yes	No	Details		Yes	No	Details
Asthma	☐	☐		High Blood Pressure	☐	☐	
AIDS/HIV	☐	☐		Hepatitis	☐	☐	
Allergies	☐	☐		Heart Problems	☐	☐	
Arthritis	☐	☐		Cold Sores	☐	☐	
Bleeding Disorder /Bleed Easily	☐	☐		Joint Replacement	☐	☐	
Blood Transfusion	☐	☐		Kidney Problem	☐	☐	
Cancer	☐	☐		Lupus	☐	☐	
Skin Cancer	☐	☐		Psoriasis	☐	☐	
Diabetes	☐	☐		Tuberculosis	☐	☐	
Eczema or Dermatitis	☐	☐		Heart Valve Replacement	☐	☐	
Hives	☐	☐		Pacemaker	☐	☐	

PLEASE FLIP THE PAGE OVER TO COMPLETE THE OTHER SIDE

Please list any other medical problems you have: _____

_____

Do you have any family history of the following problems:

	Yes	No	Family Member	Details
Skin Cancer	☐	☐		
--Melanoma	☐	☐		
--Basal Cell	☐	☐		
--Squamous Cell	☐	☐		
Skin Disease	☐	☐		
Other	☐	☐		

Do you currently or have you ever smoked? Yes ☐ No ☐

If yes, how many packs per day?_____ For how long?_____

If you quit, how long ago did you quit?_____

Do you drink alcohol? Yes ☐ No ☐

If yes, how many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? _____

Do you use any illicit drugs? Yes ☐ No ☐ If yes, what kind(s)? _____

Do you wear sunscreen? Yes ☐ No ☐ If yes, what SPF?_____

What is your occupation? _____

Please check the box if you are currently experiencing any of the following symptoms:

☐	Fever/chills	☐	Difficulty swallowing	☐	Change in urinary habits
☐	Unintentional weight loss	☐	Cough	☐	Joint pain
☐	Weight gain	☐	Chest pain	☐	Muscle aches
☐	Appetite difficulties	☐	Irregular heartbeat	☐	Weakness
☐	Sleeping problems	☐	Shortness of breath	☐	Headaches
☐	Blurred/double vision	☐	Numbness/coldness of toes/feet	☐	Memory loss
☐	Loss of vision	☐	Heartburn	☐	Depression
☐	Sinus problems	☐	Nausea/vomiting	☐	Anxiety
☐	Mouth sores	☐	Change in bowel habits	☐	Seizures

FOR WOMEN:

Are you currently pregnant? Yes ☐ No ☐ If yes, when is your due date? _____

Are you currently breastfeeding? Yes ☐ No ☐

Have you had a hysterectomy? Yes ☐ No ☐