# Laguna Woods Dermatology

## Patient Registration Form

**Visit date:** _____

**Name:** _____
*First* *Middle* *Last*

**Date of Birth:** _____ **Social Security Number:** _____

**Nickname (optional):** _____ **Sex:** ☐ **M** ☐ **F**

☐**Mr.** ☐**Mrs.** ☐**Dr.**

☐**Ms.** ☐**Miss**

**Address:** _____
Street

_____
*City* *State* *Zip*

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

**Email:** _____ **Employer:** _____

**Primary Care Physician:** _____ **Phone:** _____

**Referring Physician:** _____ **Phone:** _____

**Nearest Relative: Name:** _____**Relationship:** _____ **Phone:** _____

**Do we have your permission to:**

**Leave a message on your answering machine at home?** ☐**Yes** ☐**No**

**Leave a message at your place of employment?** ☐**Yes** ☐**No**

**Discuss your medical care with any member of your household?** ☐**Yes** ☐**No**

**If yes, whom:** _____

## Insurance Information

(Please present insurance card at time of check in.)

**Primary Insurance Carrier:** _____

**Insured's ID Number:** _____

**Group Number:** _____

**Secondary Insurance (if any):** _____

**Insured's ID Number:** _____

**Group Number:** _____

**If Insured other than Patient, please complete the following:**

**Name:** _____
*First* *Middle* *Last*

**Social Security Number:** _____ **D.O.B.** _____

**Address:** _____
*Street*

_____
*City* *State* *Zip*

**Patient's Relationship to Insured (ie. child, spouse etc.)** _____

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

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

**Patient or Responsible Party Signature** _____ **Date** _____

# Laguna Woods Dermatology

## Medical Questionnaire

**Name:** _____ **Date:** _____

**MAIN REASON FOR VISIT:** _____

**Do you have or have had any of the following?** (If yes, please check)

- ☐ Heart disease
- ☐ High blood pressure
- ☐ Lung disease
- ☐ Liver disease or hepatitis
- ☐ Kidney disease
- ☐ Diabetes
- ☐ Heartburn/Ulcers/Gastritis/Reflux
- ☐ Skin cancer (Basal or Squamous cell carcinoma)
- ☐ Melanoma
- ☐ Cancer (other than skin)
  Please list: _____
- ☐ Cold sores/ Herpes
- ☐ Autoimmune disease (lupus, rheumatoid arthritis)
- ☐ Thyroid trouble
- ☐ Seizures
- ☐ Eczema or psoriasis
- ☐ Seasonal allergies or asthma
- ☐ Chronic Fatigue/Fibromyalgia
- ☐ Mechanical heart valve
- ☐ Artificial joints or metal implant
  (If yes, date of last surgery _____)
- ☐ Pace-maker
- ☐ HIV

**List any other diseases or medical conditions**

_____ _____ _____

_____ _____ _____

**List major surgeries**

_____ Date: _____ _____ Date: _____

_____ Date: _____ _____ Date: _____

**Are you taking any medications (including over the counter)?** ☐ yes ☐ no

(If yes, please list or give pre-written list to nurse)

_____ _____ _____

_____ _____ _____

_____ _____ _____

**Are you allergic to any medications?** ☐ yes ☐ no

(If yes, please list)

_____ _____ _____

_____ _____ _____

**Do you take Coumadin or blood thinners?** ☐ yes ☐ no

**Do you take aspirin daily?** ☐ yes ☐ no

**Do you need antibiotics before surgery or dental work?** ☐ yes ☐ no

**Are you pregnant or nursing?** ☐ yes ☐ no

**Are you allergic to any local anesthesia?** ☐ yes ☐ no

**(Over)**

**Do you smoke?** ☐ yes ☐ no

**Do you drink more than 20 alcoholic beverages per week?** ☐ yes ☐ no

**Are you taking any herbs or vitamins?** ☐ yes ☐ no

**(If yes, please list)**

_____ _____ _____

_____ _____ _____

**Have any of your relatives had any of the following conditions?** **(If yes, please check)**

| | | |
|---|---|---|
| ☐ Skin cancer | ☐ Seasonal allergies | ☐ Autoimmune disease |
| ☐ Melanoma | ☐ Asthma | ☐ Eczema or psoriasis |

**What do you do for a living?** _____

**Did you have greater than 5 blistering sunburns in your childhood?** ☐ yes ☐ no

**Do you wear sunscreen?** ☐ yes ☐ no

**Have you had any occupations where you worked outside in the sun?** ☐ yes ☐ no

**(If yes, please list)**

_____ _____ _____

_____ _____ _____

**Do you have any hobbies where you spend time outdoors?** ☐ yes ☐ no

**(If yes, please list)**

_____ _____ _____

_____ _____ _____

**Have you recently had any of the following? (Check if you have any of the following)**

| | | |
|---|---|---|
| ☐ Weight change | ☐ Stiffness of neck | ☐ Blood in urine |
| ☐ Fatigue | ☐ Cough | ☐ Hair Loss |
| ☐ Fevers/chills | ☐ Chest pain | ☐ Muscle or joint pains |
| ☐ Double vision | ☐ Palpitations | ☐ Fainting or passing out |
| ☐ Ringing in ears | ☐ Shortness of breath | ☐ Easy bruising or bleeding |
| ☐ Sinus problems | ☐ Heartburn | ☐ Nervousness |
| ☐ Sore gums | ☐ Vomiting | ☐ Keloids or scarring problems |
| ☐ Sore throats | ☐ Diarrhea | ☐ Depression |
| ☐ Swollen glands in neck | ☐ Constipation | ☐ Irregular menstrual cycles |

**How did you find us?**

| | |
|---|---|
| ☐ Physician (Name:_____) | ☐ Insurance book |
| ☐ Friend or family member (Name:_____) | ☐ Internet |
| ☐ Yellow Pages | ☐ Other: _____ |

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

With my consent, Michelle Algarin, M.D. or Karl Bassler, M.D. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notices of Privacy Practices prior to signing this consent. Michelle Algarin, M.D. and Karl Bassler, M.D. reserve the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to 23961 calle de la Magdalena, Suite 520, Laguna Hills, CA 92653.

With my consent, Michelle Algarin, M.D. or Karl Bassler, M.D. may call my home or designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Michelle Algarin, M.D. or Karl Bassler, M.D. use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign, Michelle Algarin, M.D. or Karl Bassler, M.D. may decline to provide treatment to me.

_____

*Signature of Patient or Legal Guardian*

_____ _____

*Patient's Name* *Date*

# FINANCIAL AGREEMENT

**FINANCIAL AGREEMENT:**

For and in consideration of services rendered, I agree to make in-full prompt payment to Michelle Algarin, M.D. or Karl Bassler, M.D. when billed for any and all charges not covered or paid by valid insurance benefits.

Initial: _____

**ASSIGNMENT OF BENEFITS:**

I authorize payment directly to Michelle Algarin, M.D. or Karl Bassler, M.D. for medical insurance benefits payable to me under terms of my policy but not to exceed the balance due for services performed during this period of treatment.

**MEDICARE:**

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carrier any information need for this or a released Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for physician services to the physician or organization furnishing the services. This authorization is valid until revoked in writing.

_____ _____

*Patient Signature* *Date*

**PRIVATE INSURANCE & MEDIGAP POLICIES:**

I authorize _____ Insurance Company to make payment of
(Name of Insurance Carrier)
authorized benefits to be made on my behalf. I assign benefits payable for physician services to the physician or organization furnishing the services. This authorization is valid until revoked in writing.

_____ _____

*Patient Signature* *Date*

**Meaningful Use Data**

Name: _____

Email: _____

Do you smoke?

( ) Current Smoker: Packs per day _____

( ) Current every day smoker

( ) Current occasional smoker

( ) Former smoker

( ) Nonsmoker

Insurance companies and Medicare have asked us to collect the following information:

(Please circle your answer)

Race: Decline to report Caucasian African American Asian Other

AND

Ethnicity: Hispanic or Non-Hispanic

They have also requested we send and receive prescriptions to your pharmacy electronically. Please sign below if you give us permission to send and receive information electronically from your pharmacy?

X _____

Pharmacy

Please enter the pharmacy below that you would like us to send your prescriptions. We can usually find your pharmacy in our system if you provide us with the name and city or street.

Pharmacy _____ Street _____

Telephone ---------- City _____