

Laguna Woods Dermatology

Patient Registration Form

Visit date: _____

Name: _____
First Middle Last

Date of Birth: _____ Social Security Number: _____

Nickname (optional): _____ Sex: M F

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)

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

- | | | |
|--------------------------------------|---|--|
| <input type="checkbox"/> Skin cancer | <input type="checkbox"/> Seasonal allergies | <input type="checkbox"/> Autoimmune disease |
| <input type="checkbox"/> Melanoma | <input type="checkbox"/> Asthma | <input type="checkbox"/> 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)

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

How did you find us?

- | | |
|--|---|
| <input type="checkbox"/> Physician (Name: _____) | <input type="checkbox"/> Insurance book |
| <input type="checkbox"/> Friend or family member (Name: _____) | <input type="checkbox"/> Internet |
| <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> 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