peninsula dermatology
medical group, inc.

Name: _____ Date of Birth: _____

Preferred Language: _____ Primary Care Doctor: _____

Referring Source **(Check All Applicable)**: Referring Doctor: _____

☐ Yellow Pages ☐ Doctor **Race**: _____

☐ Family/Friend ☐ Yelp Ethnic Group **(Circle One)**:

☐ Insurance Co. ☐ Other: _____ Decline to Specify – Hispanic/Latino – *Not* Hispanic/Latino

Preferred **Pharmacy Name**: _____

Pharmacy Location: _____ Pharmacy Phone: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Past Medical History: (please circle all that apply)

Anxiety	Autism Spectrum Disorder	Organ Transplant
Arthritis	Depression	Hyperthyroidism
Asthma	Diabetes	Hypothyroidism
Atrial fibrillation	End Stage Renal Disease	Leukemia
Bone Marrow Transplant	GERD	Lung Cancer
Breast Cancer	Hearing Loss	Lymphoma
BPH	Hepatitis	Prostate Cancer
Colon Cancer	High Blood pressure	Radiation Treatment
COPD	HIV/AIDS	Seizures
Coronary Artery Disease	High Cholesterol	Stroke

Other _____ **NONE**

Past Surgical History: (please circle all that apply)

Appendix (Appendectomy)	Heart: Biological Valve Replacement	Ovaries: Endometriosis
Bladder (Cystectomy)	Heart: Coronary Artery Bypass Surgery	Ovaries: Ovarian Cancer
Breast Biopsy (Right – Left – Both)	Heart: Heart Transplant	Ovaries: Cyst OR Tubal Litigation
Lumpectomy (Right – Left – Both)	Heart: Mechanical Valve Replacement	Pancreas: Pancreatectomy
Mastectomy (Right – Left – Both)	Heart: PTCA	Prostate: Biopsy – Cancer – TURP
Colon: Colon Cancer Resection	Joint Replacement: **Hip** (Right – Left – Both)	Rectum: APR – Low Anterior Resection
Colon: Diverticulitis	Joint Replacement: **Knee** (Right – Left – Both)	Spleen (Splenectomy)
Colon: Inflammatory Bowel Disease (IBS)	Kidney: Biopsy – Removal – Transplant	Testicles (Orchiectomy)
Colon: Colostomy	Liver: Hepatectomy – Transplant – Shunt	Uterus: Fibroids
Gallbladder (Cholecystectomy)		Uterus: Uterine Cancer – Cervical Cancer

Other _____ **NONE**

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Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratosis	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	

Other_____

Do you wear Sunscreen?	Yes	No	If yes, what SPF? _____
Do you have a history of tanning bed use?	Yes	No	
Do you have a *family* history of Melanoma:	Yes	No	Relative: _____
Do you have a *personal* history of Melanoma:	Yes	No	Date/Year of Diagnosis: _____
Do you have a *family* history of other skin cancer:	Yes	No	
Do you have a *personal* history of other skin cancer:	Yes	No	

Medications: (Please enter all current medications, dose not required) *If none, circle:* **NONE**

_____

_____

_____

Drug Allergies: *If none, circle:* **No Known Drug Allergies**

_____

_____

_____

Social History: (Please circle all that apply)

Cigarette Smoking:

Current every day smoker	Current *someday* smoker
Former smoker	Never smoked

Alcohol Use (Circle One): NONE
less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

Please CIRCLE:

Allergy to adhesive	Yes	No
Allergy to lidocaine	Yes	No
Allergy to topical antibiotic ointments	Yes	No
Artificial heart valve	Yes	No
Artificial joints	Yes	No
Blood thinners	Yes	No
Defibrillator	Yes	No
MRSA	Yes	No
Pacemaker	Yes	No
Premedication prior to procedures	Yes	No
Rapid heartbeat with epinephrine	Yes	No
Pregnant or planning a pregnancy	Yes	No
West Africa: Travel or Contact	Yes	No
*History of fainting, anxiety, or dizziness when receiving medical treatment?	Yes	No
Ebola risk – contact, travel, or sickness?	Yes	No

Do you have a *present* illness of:

Problems with bleeding	Yes	No
Problems with healing	Yes	No
Scarring (keloid/hypertrophic)	Yes	No

***Latex Allergy:** **Yes** **No**

*****Is it ok to leave a detailed message?**
YES: Cell/Home/Work **NO**

_____
Email

PATIENT REGISTRATION FORM

PLEASE PRINT **CLEARLY**

Date:_____

Patient Name: _____, _____ Date of Birth:_____ Sex: **M F**
LAST FIRST MI

Address_____ Marital Status___
STREET CITY STATE ZIP APT #

Preferred Daytime Phone: (_____)_____ Phone: (_____)_____
Circle: Home - Cell Home - Work - Cell

Email Address: _____ **Preferred Contact Method** (Circle One): Phone – Letter - Email

Social Security#:_____ Driver's License #_____Employer_____

Insurance Information:

PRIMARY Insurance carrier:_____ID#_____Group#_____

Subscriber* Name**:_____ ***Subscriber DOB:_____/_____/_____

Subscriber SS#_____-_____-_____ Sub. Employer:_____ Relationship to insured_____

SECONDARY Insurance carrier:_____ID#_____Group#_____

Subscriber Name:_____ ***Subscriber DOB***:_____/_____/_____

Subscriber SS#_____-_____-_____ Sub. Employer:_____ Relationship to insured_____

As a patient or legal guardian of a minor patient*, I agree to pay for all services rendered. This office may bill my insurance carrier as needed. **ASSIGNMENT & RELEASE**: I hereby authorize payment of medical and/or surgical benefits directly to Peninsula Dermatology Medical Grp., Inc. for services rendered. I understand that I am financially responsible for charges not covered or denied by my insurance for whatever reason - See Financial Policy Form. I authorize this office to release any information necessary to process this request.

SIGNATURE _____ DATE:_____

If the patient is a minor* (under the age of 18) **authorizing parent information **REQUIRED** below (Please print)

***Parent** Name:_____ *Date of Birth:_____/_____/_____
LAST FIRST MI

*Address:_____ *Relationship to patient_____
STREET CITY STATE ZIP APT #

*Social Security#:_____ Daytime Phone: (_____)_____Phone: (_____)_____
CIRCLE: Home - Work - Cell Home - Work - Cell

Acknowledgement of Receipt of Notice of Privacy Practices

I have read the Privacy Notice and understand my rights contained in the notice.
By way of my signature below, I provide this practice with my authorization and consent to use and disclose my Protected Healthcare Information (PHI) for the purposes of treatment, payment, and healthcare operations as described in the Privacy Notice.

If you would like to authorize anyone to receive or give information about you, please complete:

I hereby authorize Peninsula Dermatology Medical Group, Inc. to disclose information about me to:

_____
Name(s)

_____
Relationship to patient (Spouse/Child/Parent/Conservator, etc)

Or _____ Initial if you do *NOT* want your medical information to be shared with anyone other than your team of physicians and insurance company, when necessary.

If you are signing as the patient's representative:
**Print your name:* _____ *Describe your authority/relationship to patient:* _____

_____ _____
Patient's Signature (Or authorized parent/representative) Date

PENINSULA DERMATOLOGY MEDICAL GROUP, INC.

Diseases of the Skin • Dermatologic Surgery • Laser Surgery • Mohs' Surgery

1750 El Camino Real #206, Burlingame, CA 94010 **Tel:** (650) 692-0182 **Fax:** (650) 692-8116

Dear Patient,

Welcome to our office. It is the policy of Peninsula Dermatology to follow all federal and state laws and reporting requirements regarding identity theft. Please be informed that it is a **requirement that you bring a photo ID** issued by a local, state or government agency (valid driver's license, passport, employee ID card, student ID card or current utility bill if photo ID is not available) to your appointment. If the patient is a minor, the patient's parent/ guardian should bring the information listed above. You will also need your **insurance card, referral/authorization** if needed, and any co-payment that is due. **Please note if you do not have your insurance card with you, our office policy treats you as a "cash pay" patient and you will be required to pay at the time of your visit. We do not accept personal checks.**

Cancellations/Reschedules/No Shows: For new patients, we require a Credit/Debit Card on file to secure any appointment. If you are unable to keep your appointment, we ask that you kindly provide us with at least 48 hours notice. This courtesy, on your part, will make it possible to give your appointment to another patient. If you do not call to cancel or reschedule your appointment within 24 hours there will be a $50.00 fee for no shows and same day cancellations.

Thank you for your cooperation and assistance complying with the above requests.

Providers and Staff of Peninsula Dermatology Medical Group

I have read and understand the above policy:

Patient Name **Signature** **Date**

PENINSULA DERMATOLOGY MEDICAL GROUP, INC.

FINANCIAL POLICY

We are committed to providing you with the best possible medical care and are pleased to discuss our professional fees with you at any time. Our billing department can be reached directly by calling (650) 692-0789. Your clear understanding of our financial policy is important to our relationship.

All patients must complete our patient information sheet and supply us with a copy of their insurance card(s) with proof of identification on a yearly basis. If any information has changed during the year, we will ask that you fill out new forms and allow us to take copies of your new insurance card(s).

Payment at the time of service is required as follows:

HMO Patients:	Co-payment, if applicable, provided you or your PCP/Medical Group has furnished us with proper authorization/referral for treatment.
PPO/POS Patients:	Co-payment, if applicable and/or annual deductible amount. Please note, if we are not contracted with your 1st tier medical group, e.g., Mills Peninsula or Brown and Toland Medical Group, the claim will be submitted using your "out of network" benefits. Co-insurance and deductibles will apply.
Cash Patients:	Payment in full is due at the time of service unless a prearranged financial agreement has been arranged.
Cosmetic Procedures:	Payment for all cosmetic procedures are due at the time of service and are not billable to your insurance company.

If you do not have the proper authorization/referral or if this is pending and/or you do not have proof of insurance (no insurance card) you will be treated as a "Cash Patient". _____ (please initial)

We accept Cash, Visa, MasterCard and Discover. We do not accept personal checks.

Billing Your Insurance:
As a courtesy to you, we will bill your primary and secondary insurance only. However, to do so, we must have the most up to date insurance cards provided to us prior to services being rendered otherwise; payment in full will be required. _____ (please initial)

We will not become involved in disputes between you and your insurance company regarding eligibility, deductibles, co-payments, covered charges, etc. other than to supply pertinent medical information as required.

You are responsible for timely payment of your account.

Thank you for reviewing our policy. Please bring questions or concerns to the attention of our billing office.

Please sign below as an indication that you have read and agree to the above Financial Policy.

Patient/Guardian (Print) (Signature) Date

Street Address City State Zip

1750 El Camino Real, Suite 206, Burlingame, CA 94010
650-692-0182 (Fax) 650-692-8116