Island Dermatology, Inc

Island Dermatology, Inc
360 San Miguel Dr. #501 Newport Beach, CA 92660
949-720-1170

DBA Advanced Dermatology
210 S. Grand Ave. Glendora, CA 91741
626-914-3675

DBA Dermatology Associates of Downey
8345 Firestone Blvd. # 310 Downey, CA 90241
562-923-3001

Desert Dermatology, Inc
12611 Hesperia Rd. Ste. A Victorville, CA 92395
760-951-7762

DBA Santa Ana Dermatolgy
2621 S. Bristol St. # 309 Santa Ana, CA 92704
949-720-1170

Patient Registration

Name _____ Driver's Lic. # _____
Last First Initial

Address _____ City_____ State_____ Zip_____

Home Phone _____ Cell Phone_____ Work Phone _____

Best Phone Number to call for appointment reminders and results: Home / Cell _____

Sex: M_____ F _____ Birth date _____ Maiden Name_____

Patient Employed By_____ Business Address _____

Name of Spouse _____ Spouse Cell Phone _____

☐ **I consent to electronic communication via email and or text, including but not limited to communication about my medical condition and advice from my health care providers by the following means:**

E-mail address you are consenting to communicate through: _____

Phone Number you are consenting to communicate through: _____

In case of emergency, who should be notified? _____ Phone _____

If visiting from out of town, please provide a local phone number _____

Referred by: Doctor_____Friend/Relative_____ Other _____

Primary Insurance

Subscriber Name _____
Last First Initial

Subscriber Birth date_____ SSN #_____ Relation to Patient_____

Secondary Insurance

Is Patient covered by additional insurance? Yes____ No_____

Subscriber Name _____
Last First Initial

Subscriber Birth date _____ SSN #_____ Relation to Patient_____

Acknowledgement of Receipt of Notice of Privacy Practices

Island Dermatology reserves the right to modify the privacy practices outlined in this notice.

I have reviewed or received a copy of the Notice of Privacy.

_____
Name of Patient (please print)

_____ _____ _____
Signature of Patient/Signature or Patient Representative **Relationship to patient** **Date**

Please note that State and Federal Law provides additional protections for minors and restricts the release of certain patient information to anyone other than the minor patient.

Name of Person Completing this form _____ Date_____

A signed Financial Agreement is also required prior to treatment

Staff Int._____

PRACTICE/PATIENT FINANCIAL AGREEMENT

Patient Name: _____ Date: _____
(Please print)

We are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask you adhere to the following guidelines:

1. Proof of Insurance and Photo ID are required for all patients.

2. It is your responsibility to provide us with your current address, telephone number and insurance information at each visit.

3. **It is your responsibility to contact your insurance carrier to confirm that our physicians participate in your plan as well as to know your benefit levels (Deductibles, co pays). If you see a doctor that is not currently on your plan, you will be responsible for payment in full. Please be advised it is Your responsibility to request what charges will be sent to insurance Prior to services performed. At that time a quote will be provided for what will be billed to insurance we are Unable to to advise of your final patient responsibility until claim has been processed by your insurance,**

4. **WE DO NOT ACCEPT CHECKS FOR COPAYMENTS OR SELF PAY/COSMETIC PROCEDURES.**

5. In order to schedule a surgical procedure we will collect in advance any **unmet** deductibles/co-insurance that are set forth by your insurance.
   - **Payment in full on any patient balance is expected at check-in.**
   - **$10.00 service fee will be charged for failure to pay copayment at time of service.**

6. If you miss your appointment or do not cancel within **24 business hours** you will be charged a **$50.00** fee that will be due **prior** to rescheduling a new appointment.

7. All medical record requests must be in writing and received in our office **72 hours prior** to the date needed; **$25.00** records copying fee required for charts larger than10pgs.

8. The adult accompanying a minor and the parents (or guardians) are responsible for full payment.

9. **Parent/Guardian must be present for first visit.**
   For unaccompanied minors, non-emergency treatment will be denied unless consent for treatment is on file and payment arrangements have been made and verified to be on file in advance.

10. **PPO/POS/EPO Patients**; please be aware that for biopsy specimens it may be necessary to utilize an "**Outside Laboratory**". You will receive a separate bill from them in addition to a bill from us for services rendered. Patient to advise our office of their Lab preferences **prior** to procedures; we will do our best to accommodate lab choice.
    If no designated lab is listed patient agrees to terms outlined. Please initial _____

    Designated Lab Per Patient Request _____

I have read and understand the Financial Policy set forth by Island Dermatology, Desert Dermatology

For Minor Patients, Responsible Parties Name_____Relationship_____

Patient or Responsible Parties Signature _____ Date_____

ISLAND DERMATOLOGY - PATIENT INFORMATION FORM

Patient Name: _____Date of Birth:_____Today's Date_____

Who is your Primary Care Provider: _____ NEW VISIT / ESTABLISHED PT

Please list any allergies to medications : None / _____

Preferred Pharmacy
(Name/Street/City) : _____

Reason for today's visit – Skin Check / Growth / Rash / Acne

CHILDREN OR IF AGE <19yo – Height _____ Weight _____

Please answer the following questions:

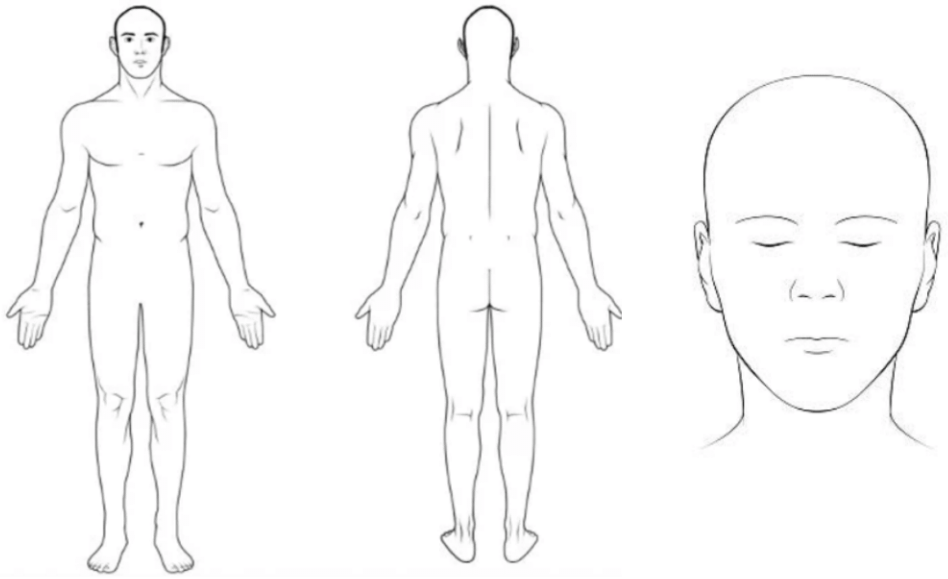
Do you have a history of:

Y	/	N	Basal Cell Skin Cancer
Y	/	N	Squamous Cell Skin Cancer
Y	/	N	Malignant Melanoma Skin Cancer
Y	/	N	Blood Thinners
Y	/	N	Pacemaker or Defibrillator
Y	/	N	Artificial Heart Valve or Artificial Joints in the last 2 years
Y	/	N	Diabetes
Y	/	N	HIV
Y	/	N	Immunosuppression / Organ Transplant
Y	/	N	Allergy to Lidocaine
Y	/	N	Brain Shunt
Y	/	N	Currently Pregnant
Y	/	N	Currently Breastfeeding
Y	/	N	High Blood Pressure

OFFICE USE ONLY

Exam: Face Waist Total

_____ New OTC/Rx
_____ Close Contact
_____ Mucosal
_____ Fever



____ Uploaded to patient chart

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HIPAA CONSENT FORM
CONSENT TO LEAVE MESSAGE

Patient Name: _____ Date of Birth: _____

I wish to be called at the following number(s) regarding my care and follow-up of pathology and lab results.

Phone: (_____)_____

I give my permission to leave relevant medical information on my answering machine or voice mail.

Extended Authorization Option
Please list any person(s) you would like to authorize to have access to your billing, appointment or health information (with exclusion of information that is protected under State Federal Law) such as your spouse, caretaker, or other family member. If none, please state "None" below:

Name:	Relationship:
_____	_____
_____	_____
_____	_____

_____ _____
Patient Signature Date
Signature of Patient Representative
If patient is a minor _____
Relationship to Patient if Minor
(Required if patient is a minor or an adult who is unable to sign this form)

Please note State and Federal law provide additional protection for minors and restricts the release of certain patient's information to anyone other than the minor's parent.