OFFICE USE ONLY
Patient Name: ____________
Date: ______ Account #: ________ Reviewed by: ____

PATIENT INFORMATION

Last Name: ____________ First Name: ________________ Middle Initial: ________

Address: ____
Street City State Zip Code

Home #: ____________ Cell Number: ____________ Work #: ____________

Date of Birth: ____________ Age: ____________

Sex: ____________ Marital Status: ____________ Email: ________________

Race: (Circle one) Caucasian Hispanic/Latino Asian African American Middle Eastern

Languages Spoken: ____

Emergency Contact: ____________ Relationship: ____________ Phone #: ____________

Patient Occupation: ____________ Employer: ________________________

Referring Physician: ____________ Primary Care Physician: ________________________

Pharmacy: ____________ Address: ________________________

How did you find us/referred by: ______________________________________

INSURANCE INFORMATION (Please fill out if patient is not the insured):

Last Name of Insured: ____________ First Name of Insured: ________________ MI: ________

Address: of Insured ____
Street City State Zip Code

Home #: ____________ Cell Number: ____________ Work #: ____________

Date of Birth of insured: ____________ Sex (of insured): ________________________

OFFICE USE ONLY					
Patient Name:					
Date:		Account #:		Reviewed by:	

FINANCIAL AGREEMENT – ALL PATIENTS, INCLUDING MEDICARE

Payment is required for all services rendered at that time. The patient is responsible for any/all charges not paid for by their insurance company.

I have read and understand the financial agreement. I agree to make in-full prompt payment to Shirlene Jay, M.D., Inc. when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered. Further, I authorize payment directly to Shirlene Jay, M.D., Inc. for medical insurance benefits payable to me under the terms of my policy but not to exceed the balance due for services performed for my treatments. This authorization is valid until revoked in writing.

Patient Signature *Date (mm/dd/yy)*

FINANCIAL AGREEMENT – MEDICARE PATIENTS ONLY

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 and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed 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 to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. This authorization is valid until revoked in writing.

Patient Signature *Date (mm/dd/yy)*

RELEASE OF MEDICAL INFORMATION

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 application, and prescriptions.

Patient Signature *Date (mm/dd/yy)*

PRIVACY PRACTICES (HIPPA)

Notification and Receipt of Privacy Practices:

- By signing below, I acknowledge that I have the right and opportunity to review the Notice of Privacy Practices. Notice of Privacy Practices may be obtained by forwarding a written request South Bay Dermatology, Privacy Officer at 3400 Lomita Blvd. #104, Torrance, CA 90505.

Contact Information:

- By signing below, I authorize South Bay Dermatology to leave a message in reference to any items that assist the practice in carrying out healthcare operations. If you do not wish to be contacted at a specific location, please indicate below:

Home Phone:	☐ Do not contact me here		Work Phone:	☐ Do not contact me here
Mobile Phone:	☐ Do not contact me here		Email:	☐ Do not contact me here

Please list any persons to whom your protected information can be disclosed (e.g., spouse, parent)

Name:		Relationship:	
Name:		Relationship:	

Patient Signature *Date (mm/dd/yy)*

OFFICE USE ONLY
Patient Name: ____________
Date: ________ Account #: ________ Reviewed by: ______

APPOINTMENT CANCELLATION POLICY

In order to maintain efficiency in the scheduling of our patients, our office has found it necessary to implement an appointment cancellation policy.

If you wish to cancel or reschedule your appointment, please call at least 24 hours in advance of your scheduled time.

A $50.00 cancellation fee will be charged immediately to your account if our office is not given a timely notice. This is not covered by your insurance.

A $100.00 cancellation fee will be charged to your account for surgical and or cosmetic procedures if our office is not given a timely notice.

I have been informed and acknowledge this policy.

Signature: ______________________________

Print Name: ______________________________

OFFICE USE ONLY					
Patient Name:					
Date:		Account #:		Reviewed by:	

PATIENT HEALTH QUESTIONNAIRE

PAST MEDICAL HISTORY: Please check or circle if you had or have any of the following conditions:

- ☐ anxiety
- ☐ arthritis
- ☐ artificial joints date ____________
- ☐ asthma
- ☐ atrial fibrillation/irregular heartbeat
- ☐ bone marrow transplant
- ☐ BPH
- ☐ breast cancer
- ☐ colon cancer
- ☐ COPD
- ☐ coronary artery disease
- ☐ depression
- ☐ diabetes type _________
- ☐ end stage renal disease
- ☐ GERD
- ☐ hearing loss
- ☐ hepatitis
- ☐ hypertension
- ☐ HIV/AIDS
- ☐ hypercholesterolemia
- ☐ hyperthyroidism
- ☐ hypothyroidism
- ☐ leukemia
- ☐ lung cancer
- ☐ lymphoma
- ☐ prostate cancer
- ☐ radiation treatment
- ☐ seizures
- ☐ stroke
- ☐ other ___________________________

PAST SURGERIES
If yes, what and when? ____

SKIN DISEASE HISTORY: Please check or circle if you had or have any of the following conditions:

- ☐ acne
- ☐ actinic keratosis
- ☐ asthma
- ☐ Basal cell skin cancer
  date/area _________________________
- ☐ blistering sunburns
- ☐ dry skin / itchy
- ☐ eczema
- ☐ flaking or itchy scalp
- ☐ hay fever/allergies
- ☐ melanoma
  date/area _______________________
- ☐ poison ivy
- ☐ precancerous moles
- ☐ psoriasis
- ☐ squamous cell skin cancer
  date/area ___________________________
- ☐ Family history of melanoma
  Whom? ____________________________

Do you use a tanning salon? _______________ Do you use sunscreen? __________________ If yes, what SPF? ________________________

CURRENT MEDICATIONS ____

____
(including over-the counter, vitamins or supplements)

ALLERGIES TO MEDICATIONS ____

Please describe the type of allergic reaction you have: ________________________________

South Bay Dermatology

OFFICE USE ONLY					
Patient Name:					
Date:		Account #:		Reviewed by:	

SOCIAL HISTORY: Please circle and fill in your answer if appropriate

Smoker present or past
If currently smoker list amount: ________________

Recreational drug use
If yes, list type ____________________

Alcohol use
If yes, list amount/week ___________________

REVIEW OF SYMPTOMS: Please check or circle if you had or have any of the following conditions:

☐ fevers or chills	☐ dizziness	☐ Tuberculosis
☐ night sweats	☐ abdominal pain	☐ emphysema
☐ Unintentional weight loss	☐ ulcers	☐ shortness of breath
☐ muscle aches	☐ cough	☐ phlebitis/painful veins
☐ joint aches	☐ sore throat	☐ herpes oral/genital

ALERTS: Please check or circle if you had or have any of the following conditions:

☐	pacemaker		☐	difficulty stopping bleeding		☐	pregnancy/planning pregnancy
☐	defibrillator		☐	blood thinners		☐	breastfeeding
☐	artificial joints (within past 2 years)		☐	allergy to adhesives		☐	HIV/AIDS
☐	Artificial heart valve		☐	allergy to antibiotic treatments		☐	Hepatitis B or C
☐	stent		☐	allergy to lidocaine		☐	history of MRSA
☐	premedication prior to procedures		☐	rapid heartbeat w/epinephrine		☐	immunosuppression
☐	Light headedness during procedures		☐	yeast infection w/antibiotics		☐	problems with scarring

PATIENT SIGNATURE

Signature: ____ Date: ____