# 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_____

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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

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## 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.

## 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

# 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**: 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 $100.00 fee.

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

# Open Payments Data

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at

https://openpaymentsdata.cms.gov.

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

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: _____

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**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**

***PAGE OVER→

**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**

# NOTICE TO PATIENTS

Medical doctors are licensed and regulated by the Medical Board of California.

To check up on a license or to file a complaint go to www.mbc.ca.gov,

Email: licensecheck@mbc.ca.gov, or call (800) 633-2322.

# NOTICE AND ACKNOWLEDGMENT OF RECEIPT AND UNDERSTANDING

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_____ _____

Date Patient's Name (Type or Print)

_____

Patient's Signature

_____ _____

Date Patient Representative's Name and Relationship (Type or Print)

_____

Patient's Representative's Signature

Original to be maintained in patient's medical records.