PLACER DERMATOLOGY
& Skin Care Center
9285 Sierra College Blvd., Roseville, CA 95661
Phone (916) 784-3376 Fax (916) 784-9500

If possible, please fax, send, or bring completed forms with you to the appointment.

Patient Registration Information

Patient Name: _____ **Today's Date:** _____
Last First M.I.

Date of Birth: ____/____/_____ Age: _____ Gender: ○ Male ○ Female

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed

SSN: _____ Occupation: _____ Employer: _____

Home Address: _____
City State Zip

Home Phone: ( )_____ Work Phone: ( )_____

Cell Phone: ( )_____ e-mail: _____

May we leave personal medical information on your:

Home answering machine? ○ Yes ○ No Cell Phone? ○ Yes ○ No Work Phone? ○ Yes ○ No

Do you give our office permission to discuss your medical information with family members? ○ Yes ○ No

Name: _____ Phone: ( )_____

Relationship to patient: _____

PARENT, SPOUSE, OR RESPONSIBLE PARTY *(if different from patient)*

Name: _____ Date of Birth: ____/____/_____
Last First M.I.

Relationship to patient: _____ Address: **Same as above** ☐

or_____
City State Zip

Home Phone: ( )_____ Work Phone: ( )_____ Cell Phone: ( )_____

In case of emergency, whom should we notify?

Same as above ☐ Ũb, t ame: _____

Address: _____
City State Zip

Relationship to patient: _____ Phone: ( )_____

HOW DID YOU LEARN ABOUT PLACER DERMATOLOGY? Please specify. Thank you.

○ **FAMILY/FRIEND** ○ **COMPASS** ○ **GRANITE BAY VIEW**
○ **PHONE BOOK** ○ **INTERNET** ○ **STYLE MAGAZINE** ○ **OTHER**

PRIMARY INSURANCE

Name of Insurance Company:_____

Address: _____
City *State* *Zip*

Name of Policy Holder (insured): _____ Date of Birth: ___/___/____

Policy Number: _____ Group Name or Number: _____

Policy Type: ○ HMO ○ PPO ○ Other_____

Relationship to patient: _____

SECONDARY INSURANCE

Name of Insurance Company:_____

Address: _____
City *State* *Zip*

Name of Policy Holder (insured): _____ Date of Birth: ___/___/____

Policy Number: _____ Group Name or Number: _____

Policy Type: ○ HMO ○ PPO ○ Other_____

Relationship to patient: _____

REFERRING PHYSICIAN

Name: _____ Phone Number: ( )_____
Last *First* *M.I.*

PRIMARY CARE PHYSICIAN ☐ Same as above

Name: _____ Phone Number: ( )_____
Last *First* *M.I.*

PHARMACY OF CHOICE

Name: _____ Phone Number: ( )_____

Address:

_____
City *State* *Zip*

AUTHORIZATIONS

I authorize the release of medical information to my primary care or referring physician, to any consultants as needed, and as necessary to process insurance claims and prescriptions.
I have received and/or reviewed a copy of the Notice of Privacy Practices from Placer Dermatology.
I authorize Placer Dermatology to take digital photographs for my medical record if medically necessary.

Signature: _____ Date: _____

Our office will file insurance for all reimbursable service, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductable, copay, and non-covered service amounts at the time of your visit.

Please present your insurance card(s) and your photo ID to the receptionist at check in. Thank you.

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Patient Health Questionaire

Patient Name: _____ Today's Date: _____
Last *First* *M.I.*

Reason for today's visit:

_____

_____

_____

Did another physician refer you? ◯ Yes ◯ No Name of doctor:_____

How did you find out about Placer Dermatology? Please specify. Thank you.

◯ Family/Friend ◯ Compass ◯ Granite Bay View
◯ Phone Book ◯ Internet ◯ Style Magazine ◯ Other

Current Medications (including prescriptions, over-the counter medications, vitamins and herbals):

_____

_____

Do you have now or have you ever had diseases or conditions of: ☐ No

- ☐ Asthma
- ☐ Bleeding Problems
- ☐ Blood Clots
- ☐ Cancer _____
- ☐ Diabetes
- ☐ Heart Disease _____
- ☐ Heart murmur
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Irregular Heartbeat
- ☐ Keloids (abnormal scarring)
- ☐ Kidney Disease _____
- ☐ Liver Disease/Hepatitis _____
- ☐ Mood disorder _____
- ☐ Respiratory (Lung) Problems _____
- ☐ Seasonal Allergies
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Other _____

Have you ever had local anesthesia? ◯ Yes ◯ No Any bad reactions? ◯ Yes ◯ No

Do you require antibiotics for Dental Work? ◯ Yes ◯ No

Do you have any of the following?

☐ artificial heart valve ☐ artificial joints ☐ pacemaker ☐ other metal implants

Do you develop skin rashes in reaction to: ☐ band-aids ☐ topical antibiotic _____

Do you have problems with healing? ◯ Yes ◯ No

Have you ever had any of the following skin cancers? ☐ No

☐ Basal Cell Cancer Location: _____ Treatment and date: _____
☐ Melanoma Location: _____ Treatment and date: _____
☐ Squamous Cell Cancer Location: _____ Treatment and date: _____
☐ Other_____ Location: _____ Treatment and date: _____

List any other Skin Disease you have or had: _____

Are you allergic to any medications? ◯ Yes ◯ No
If yes, list:

_____
_____
_____

List any Major Surgical Procedures and Dates: _____
_____

Family History of Skin Cancer? ◯ Yes ◯ No Type:_____
Family History of Asthma, Seasonal Allergies or Eczema? ◯ Yes ◯ No _____
Family History of any other skin disease ? ◯ Yes ◯ No _____

Social History:
Do you drink alcohol? ◯ Yes ◯ No if yes drinks per day _____
Do you smoke? ◯ Yes ◯ No if yes how much? _____
What is your occupation? _____
Hobbies _____

Do you have or have you recently had any of the following? ☐ No

☐ Bleeding problems	☐ Fever	☐ Shortness of Breath
☐ Cough	☐ Hair Loss	☐ Skin Rash
☐ Depression	☐ Headache	☐ Swollen Lymph Nodes
☐ Dizziness	☐ Joint Pains	☐ Visual Changes
☐ Fatigue	☐ Nausea or Vomiting	☐ Weight loss/gain over 10 pounds

☐ Other symptoms _____

Women only:
Are you pregnant? ◯ Yes ◯ No if yes, how many months? _____
Are you trying to conceive? ◯ Yes ◯ No
Are you breastfeeding? ◯ Yes ◯ No

The above information is correct to the best of my knowledge.

Signature of Patient (Parent or Legal Guardian if Minor):

_____ **Date:** _____

Print Name: _____

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Patient Acknowledgement of theNotice of Privacy Practices and Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal healthcare information is protected. The privacy rule was created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and sharing with other health information regarding payment and healthcare operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all that we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide only the minimum necessary information to those we feel are in need of your information in order to provide the care that is in your best interest. We also want you to know that we support your full access to your personal medical records. We may have indirect relationships with others (for example a laboratory) and may have to disclose personal health information for the purpose of treatment, payment or healthcare operations. These partners in your healthcare are also most often not required to obtain patient consent. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose all or part of your personal health information (PHI). If you choose to give consent in this document, at some future time you may request to refuse to release all or part of your PHI. You may not revoke your decisions that you have already been taken, which relied on this or previously signed consent. Our NOTICE OF PRIVACY PRACTICES describes in detail how much medical information about you may be used or shared and how you can get access to that information. There is a current copy of this notice available at the reception counter of Placer Dermatology & Skin Care Center and a full and complete copy will be offered to you at no charge. You have the right to review our privacy notice, to request and revoke consent in writing after you have reviewed our privacy notice. If you have any questions or objections to this form, please ask to speak with the Practice Manager.

Thank You !

Patient Signature: _____ Date:_____

Print Name: _____

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Practice Policies and Financial Responsibility

Patient Name:_____ **Date of Birth:** _____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. Obtaining referral forms or pre-authorization is the responsibility of the patient. In the absence of appropriate referrals or pre-authorization, the patient is responsible for payment of services. For those patients, applicable, copayments and deductible will be collected at the time of service. We accept payment in the form of cash, check, debit or credit card. In the event of a surgical procedure, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be pre verified and you will be asked to pay for any unmet deductible, non-covered services and copayments.

For Patients with Insurance
We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

Medicare Patients
We will bill Medicare for you. We will also bill secondary insurance carriers for you. All copayments or deductibles are due and payable at the time service is provided.

Surgery Fees
All co pays, deductibles, and payments for non covered surgical procedures are due prior to your surgery. Prior authorization may be required by your carrier.

Non covered Services
Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

Collections
If past bills are sent to collections, a minimum charge of $25 will be added (plus any finance charges incurred by the collections company).

Personal Injury Cases
This office does not bill for auto accident or other liability or lawsuit-related cases.
You are responsible for payment at the time of service. We do not accept liens.

Yearly Skin Screenings
Periodic preventive skin screenings may or may not be covered under your health insurance policy; however, they may be recommended by your physician.

Appointment Guidelines
There will be absolutely no charge for your need to reschedule an appointment, provided we receive a **48 hours** notice. This courtesy will provide us with the opportunity to give this time to another patient waiting to be seen. Failure to reschedule an office visit will result in a $50 fee which is not billable to insurance. Failure to cancel a surgery visit will result in a $100 fee which is not billable to insurance.

Please check one: I have paid my insurance deductible for this calendar year.
◯ Yes ◯ No ◉ Don't know

Medicare Patients: Signature on File
For the convenience of our Medicare patients and to expedite billing of services to Medicare on their behalf, Placer Dermatology will request and maintain your signature on file.

Minors
By law, patients under 18 years of age must be accompanied by a parent or legal guardian.

Copies of your Medical Record may be obtained with written consent. The charge for this service is $10.

I have read, understand, and agree to adhere to the practice policies above. I also understand and agree that such policies may be amended by Placer Dermatology as needed.

Signature: _____ **Date:**_____