Dermatology New Patient History

Name_____Date of Birth_____

Referred by_____ Primary MD_____

How did you hear about our office?_____

Occupation / Former Occupation _____ [ ] Check if Retired

Reason for Visit_____

Duration of Problem _____

Treatments Used _____

Do you have a History of any of the following? (*check yes or no*):

	Yes	No		Yes	No		Yes	No
High Blood Pressure			Cancer			Artificial Heart Valve		
Heart Attack			Hepatitis			Bleeding Disorder		
Heart Arrythmia			HIV infection			On Blood Thinners		
Atrial Fibrillation			Immunosuppression			Poor Wound Healing		
Heart Murmur			Organ Transplant			Poor Surgical Results		
Pacemaker / Defibrillator			Blood Disease			Reaction to Local Anesthetic		
Congestive Heart Failure			Memory Problems			CLL Chronic Leukemia		
Angina			MRSA infection			Swollen Lymph Glands		
Seizure Disorder			Melanoma			Fainting with Procedures		
Epinephrine Sensitivity			Skin Cancer			Antibiotics for Dental Work		
Liver Disease			Latex Allergy			Melanoma in Family		
Lung Disease			Tape Allergy			Skin Cancer in Family		
Kidney Disease			Abnormal Scars			Do You Use Sunscreen?		
Asthma			Weight Loss			Do You Smoke?		
Diabetes			Joint Replacement			Do You Drink Alcohol?		

Please list the following information (*or write none*):

Any Other Medical Problems _____

Operations/Surgeries _____

Medicines You Are Taking _____

_____

Drug Allergies_____

Family History of Medical Problems _____

For Female Patients Only: Check if you are [ ] Pregnant [ ] Breastfeeding [ ] Taking Birth Control Pills

Signature_____Today's Date _____

Nurse_____Physician Review _____

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Dermatology Patient Registration Sheet

Patient Name _____

Date of Birth _____Sex: M F Marital Status: S M DP D W

Primary Language [ ] English [ ] Spanish [ ] Other _____

Race [ ] White [ ] African American [ ] American Indian [ ] Asian [ ] Pacific Islander [ ] Other

Ethnicity [ ] Hispanic or Latino [ ] Not Hispanic or Latino

Social Security Number _____Driver's License Number _____

Local Address _____
Number Street Apt. #

_____
City State Zip Code

Phone Numbers: (_____)_____ (_____)_____ (_____)_____
Home/Local Secondary Emergency/Other

Secondary Address _____
Number Street Apt. #

_____
City State Zip Code

E-Mail Address _____

Employer & Address _____

Referring Physician _____

Medicare Number _____

Medicare Supplement_____Group/Policy # _____

MediCal Number _____

Private Insurance _____Group/Policy # _____

Insured's Name _____ Date of Birth _____

Insured's SSN _____Employer Name_____

Employer Address and Phone _____

Signature _____Today's Date _____

(See reverse side)

Revised 9/13

Consent for Treatment and Authorization for Insurance Payment

All patients, please initial and sign below

_____My initials and signature below are indication of my general consent and authorization, for this and subsequent visits, for evaluation and treatment at Mirage Dermatology including the taking of appropriate history, physical exam, and other tests or procedures necessary for my medical care.

_____My initials and signature below also authorize Mirage Dermatology, or its agent, to release to my insurance company(ies), any or all medical records in its possession, necessary for claims review and adjudication, for this and subsequent visits. I also authorize payment of medical benefits from my insurance company(ies) directly to Mirage Dermatology. I permit a copy of this authorization to be used in place of the original.

_____My initials and signature below indicate my understanding that payment by my insurance may not represent full payment for services rendered, and that I will be responsible for the balance due as allowed by my insurance carrier.

_____My initials and signature below acknowledge that I have received a copy of Mirage Dermatology's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment. I also understand that I may contact the privacy officer (Office Manager) with any questions about this Notice at (760) 341-1999.

Medicare patients only, please initial and sign below

_____My initials and signature below authorize Mirage Dermatology, or its agent, to release to the Centers for Medicare and Medicaid Services, Social Security Administration, and Medicare (or its intermediaries or carriers) any and all medical information needed for this or subsequent Medicare claims. I request that payment of medical insurance benefits be made directly to Mirage Dermatology. I permit a copy of this authorization to be used in place of the original.

_____My initials and signature below authorize Mirage Dermatology, or its agent, to release to my Medigap ("secondary insurance") carrier any and all medical information needed for this or subsequent claims. I also request that payment of medical insurance benefits from my Medigap ("secondary insurance") be made directly to Mirage Dermatology. I permit a copy of this authorization to be used in place of the original.

Signature_____Today's Date_____