GREEN DERMATOLOGIC MEDICAL GROUP
PATIENT REGISTRATION

PLEASE PRINT Date_____

Patient Name _____ Phone ( ) _____
LAST NAME FIRST NAME MI

Cell ( ) _____

Address _____

City _____ Zip _____

Date of Birth _____Sex (circle) Male Female Marital Status (circle) S M D W

Social Security # _____Drivers License # _____

E-mail address _____

Employer _____ Occupation _____

Employer Address _____Work # _____

Name of your spouse (or nearest relative) _____ Relationship _____

Who is your primary care physician?_____

Pharmacy name_____ Pharmacy Location_____

Who may we thank for referring you?_____

May we contact you at home with results? (Please circle) YES NO

Do you prefer we leave a message at your: (Circle all that apply) HOME WORK VOICE MAIL CELL PHONE

PLEASE PRESENT INSURANCE CARDS TO THE RECEPTIONIST SO COPIES CAN BE MADE

I certify that the above information is true, and I consent to any medical or surgical treatment rendered the patient under the general and special instructions of the physician.

I hereby assign all benefits to Green Dermatologic Medical Group for services rendered to me. I authorize any holder of medical information about me to release to my insurance company any information needed to determine benefits or the benefits payable for related services. I understand my signature requests that payment be made to Green Dermatologic Medical Group, and authorize release of medical information necessary to pay the claim. I have given all my insurance information for billing purposes and understand the billing procedures.

I understand that I am responsible for all charges not covered by my insurance policy including but not limited to co-payments, deductibles, and non-covered services. I also agree to complete all necessary paperwork in order for my claim to be paid by my insurance company and accept full liability if payment is not made in my behalf by my insurance company.

You signature below indicates that you understand and accept the policies listed above.

_____ Date _____
Patient Signature

GREEN DERMATOLOGIC MEDICAL GROUP

History and Intake Form

Name:_____ Date:_____

Reason for today's visit: _____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None
Other _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None
Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Any other family history: _____

Name of Pharmacy: _____ **Location** _____

Medications: (Please enter all current medications or state NONE if on no meds)

_____
_____
_____

Allergies: (Please enter all allergies or state NONE if you have no allergies)

_____
_____
_____

Social History: (Please circle all that apply)

Alcohol Use:
- Alcohol: none
- Alcohol: less than 1 drink a day
- Alcohol: 1-2 drinks a day
- Alcohol: 3 or more drinks a day

Cigarette Smoking:
- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Alert: Have you ever had a melanoma? (Please circle) YES NO

GREEN DERMATOLOGIC MEDICAL GROUP
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I hereby give my consent for Green Dermatologic Medical Group to use and disclose health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Green Dermatologic Medical Group's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Green Dermatologic Medical Group reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Green Dermatologic Medical Group Privacy Officer, 657 Camino de los Mares #242, San Clemente, CA 92673.

With this consent, Green Dermatologic Medical Group may call my home or other alternative location and leave a message on my answering machine, voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Green Dermatologic Medical Group may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Green Dermatologic Medical Group restrict how it uses or discloses my PHI to carry out TPO. However the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Green Dermatologic Medical Group's use and disclosure of my personal health information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Green Dermatologic Medical Group may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian