

# SADDLEBACK DERMATOLOGY & LASER CENTER

24432 MUIRLANDS BLVD., SUITES 219 & 227

LAKE FOREST, CA 92630

www.saddlebackdermatology.com

IRA BELL, MD

JONATHAN BARON, MD

KAREN G. BENIK, MD

JANE G. KHOURY, MD

AZIN MESHKINPOUR, MD

KIM TANG, MD

HAS ANYONE LIVING AT YOUR ADDRESS BEEN A PATIENT HERE?

(name) \_\_\_\_\_

## WERE YOU REFERRED?

PHYSICIAN (name) \_\_\_\_\_

YELLOW PAGES (which) \_\_\_\_\_

INTERNET \_\_\_\_\_

INSURANCE \_\_\_\_\_

OTHER PATIENT (name) \_\_\_\_\_

## PATIENT INFORMATION

NAME \_\_\_\_\_  
*last first middle initial*

STREET \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PATIENTS' \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Male  Female   
*age birthdate sex*

IS PATIENT *single*  *married*  *other*

IF MARRIED \_\_\_\_\_ and \_\_\_\_\_  
*spouses name birthdate*

HOME PHONE (\_\_\_\_\_) \_\_\_\_\_

WORK PHONE (\_\_\_\_\_) \_\_\_\_\_

CELL PHONE (\_\_\_\_\_) \_\_\_\_\_

E-mail address: \_\_\_\_\_  
*(Please only complete if you give us your permission to e-mail you.)*

## INSURANCE INFORMATION

**A PHOTOCOPY OF YOUR INSURANCE CARD MUST BE TAKEN TODAY AND ANY TIME YOUR INSURANCE CHANGES.**

### PATIENTS' RELATIONSHIP TO THE INSURED?

SELF  SPOUSE  CHILD

**INSUREDS' SS#** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
*enter the insureds' social*

**PATIENTS' SS#** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

ARE WE LISTED AS A PREFERRED PROVIDER BY YOUR INSURANCE? Yes  No

**PLEASE PROVIDE THE NAME AND DRIVERS' LICENSE NUMBER OF THE PERSON WHO BEARS THE FINANCIAL RESPONSIBILITY FOR THIS PATIENTS' ACCOUNT:**

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

DRIVERS' LIC. # \_\_\_\_\_ STATE \_\_\_\_\_

## PATIENT EMPLOYMENT/ STUDENT STATUS

OCCUPATION \_\_\_\_\_ EMPLOYER AND ADDRESS \_\_\_\_\_

EMPLOYED  UNEMPLOYED  \_\_\_\_\_

STUDENT    
*part time full time* \_\_\_\_\_

**Patient Registered By (employee initials)** \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION (Someone not living with you.)

NAME \_\_\_\_\_ TELEPHONE NUMBER \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_

## AUTHORIZATION

I HEREBY AUTHORIZE THE PHYSICIAN TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING THIS ILLNESS / ACCIDENT AND IRREVOCABLY ASSIGN TO THE PHYSICIAN ALL PAYMENT FOR MEDICAL SERVICES RENDERED. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR UNDERSTANDING THE TERMS AND CONDITIONS OF MY INSURANCE COVERAGE, WHETHER PRIOR AUTHORIZATION FOR SERVICE IS NECESSARY, AND FOR ALL CHARGES WHETHER COVERED OR NOT BY INSURANCE. UNPAID AMOUNTS WILL BE SUBJECT TO ADDITIONAL COLLECTION COSTS OF UP TO 25%.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
*Patient or parent/guardian of minors must sign above*

**MEDICAL HISTORY**

1) What are you seeing the doctor for today? Include all areas you plan to discuss so that time can be proportioned properly.

---

---

---

2) If the problems described above have previously been treated, please describe, including medications, below.

---

---

---

3) Please list your current prescription and nonprescription medications.

- 1) \_\_\_\_\_ 4) \_\_\_\_\_ 7) \_\_\_\_\_  
2) \_\_\_\_\_ 5) \_\_\_\_\_ 8) \_\_\_\_\_  
3) \_\_\_\_\_ 6) \_\_\_\_\_ 9) \_\_\_\_\_

4) List your recent hospitalizations (other than pregnancy) \_\_\_\_\_

---

---

5) Circle any of the following of which you have a history:

Cardiac Pacemaker    Artificial Joint    Prosthetic Heart Valve    Bleeding Disorder    Skin Infections    Diabetes

Do you require antibiotics prior to surgical or dental procedures: yes [ ] no [ ]

Do you take blood thinners? Aspirin [ ] Arthritis Medication [ ] Coumadin [ ] Other? \_\_\_\_\_

Please list other medical problems, not mentioned above: \_\_\_\_\_

---

---

6) List all medications to which you are allergic: \_\_\_\_\_

---

---

7) Use the following space to list other pertinent information: \_\_\_\_\_

---

---