SADDLEBACK DERMATOLOGY & LASER CENTER

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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 _____ _____/_____/_____
spouses name and 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 _____

EMPLOYED [ ] UNEMPLOYED [ ]

STUDENT [ ] [ ]
part time full time

EMPLOYER AND ADDRESS _____

_____

_____

_____**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: _____

_____

_____