PATIENT REGISTRATION INFORMATION

Date_____
Initial_____

Please complete both sides of this form.

PATIENT'S PERSONAL INFORMATION

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Male ☐Female

Name: _____ _____ _____ ( ) _____
last name *first name* *middle init.* *Preferred Phone*

Street Address: _____ Apt.# _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ Apt.# _____ City: _____ State: _____ Zip: _____

Alternate Phone: ( ) _____ Wk. phone: ( ) _____ E-mail: _____

Date of Birth: _____/_____/_____ Age: _____

Ethnicity (circle one): Hispanic/Latino NOT Hispanic/Latino Unknown

Race (circle one): White American Indian or Alaskan Native Asian Black or African American

Native Hawaiian or Other Pacific Islander Other Race

Language (select one): English Spanish Other (fill in): _____

Employer: _____ Occupation: _____

Spouse's Name: _____ _____ Date of Birth: _____/_____/_____
last name *first name*

Spouse's Employer's Name: _____ Phone No. ( ) _____

RESPONSIBLE PARTY INFORMATION

☐Info same as above

Responsible Party: _____ Date of Birth: _____/_____/_____

Relationship to Patient: SELF SPOUSE OTHER _____

Responsible Party's Home Phone: ( ) _____ Work Phone: ( ) _____

Street Address: _____ Apt.# _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ Apt.# _____ City: _____ State: _____ Zip: _____

Employer's Name: _____ Phone No. ( ) _____

EMERGENCY CONTACT

Name of person not living with you: _____

Relationship to you: _____ Address: _____

City: _____ State: _____ Zip: _____ Home Phone #: ( )_____

Wk. Phone #: ( )_____ Cell. Phone #: ( )_____

OTHER INFORMATION

Name of Physician/Friend/Directory who referred you: _____

Primary Care Physician: _____ Phone #: ( )_____

PATIENT'S INSURANCE INFORMATION

(Please present insurance cards and picture ID at check-in so that copies can be made)

Name of Insured: _____ Does your insurance require a referral? _____

Primary Insurance: _____ Effective Date: _____

Your Relationship to insured: SELF SPOUSE OTHER My Insurance is: ☐HMO ☐PPO ☐EPO ☐Other

Secondary Insurance: _____ Effective Date: _____

Your Relationship to insured: SELF SPOUSE OTHER My Insurance is: ☐HMO ☐PPO ☐EPO ☐Other

DMG

DERMATOLOGIST MEDICAL GROUP OF NORTH COUNTY, INC.

Financial Responsibility

ASSIGNMENT OF BENEFITS

I hereby authorize and assign payment of medical benefits to Dermatologist Medical Group of North County, Inc. (DMGNC) on my behalf for any services furnished to me by the providers of DMGNC. I further authorize DMGNC, its staff, and agents to release to my insurer or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for benefit verification, precertification, authorization, or referral to another provider. This assignment of benefits will remain in effect for future services unless terminated by me in writing.

If DMGNC is contracted with your health insurance, we will bill your insurance. However, the patient is required to understand the benefits and restrictions of their individual health insurance. If your health insurance requires a prior authorization for medical care, the patient is responsible for obtaining this, and providing proof of authorization before scheduling an appointment. It is the patient's responsibility to notify DMGNC if there are any changes to health insurance, primary care physician, address, employment, etc. Co-pays and deductibles will be collected prior to seeing a practitioner.

FINANCIAL AGREEMENT

I understand that I am financially responsible for all charges for services provided by Dermatologist Medical Group of North County, Inc., and/or its providers whether or not they are covered or paid by my health insurance. By signing this form, I agree that I am responsible for charges if they are not covered by my health insurance for any reason. In addition, I am responsible for any deductible, copay, or co-share determined by my health insurance. I further understand that in the event of default I am responsible for all costs of collection and reasonable attorney's fees. *A copy of this agreement shall be as valid as the original.*

Patient Name	Date	Patient Signature or Guardian Responsible Party

General Appointment Information

COSMETIC PROCEDURES

Cosmetic procedures are often elective, non-medically necessary treatments, and are not covered by health insurance. These procedures include but are not limited to: Botox, Daxxify, Juvéderm, RHA, Chemical Peels, VBeam Laser, IPL, Sclerotherapy, and removal of Skin Tags or Benign Growths. If a procedure is determined to be medically necessary, it can be billed to insurance. Credit Card information is required to hold any cosmetic appointments.

DISABILITY FORMS

There is a $35.00 charge for completing disability forms. This is not covered by the insurance and is therefore the patient's responsibility.

MISSED and LATE APPOINTMENTS

Your appointment time is reserved for you. Automated phone calls, texts, and emails are sent to remind you of your upcoming appointment. If you are scheduled for a procedure, you may also receive a call from one of our staff.
If you need to cancel your office visit, we require a 24 hour notice. If you need to cancel a cosmetic procedure, surgery or patch test we require a 48 hour notice. If you miss your scheduled appointment or do not cancel within the required time frame you may incur a cancellation fee. The cancellation fees are $50 for an office visit and $100 for cosmetic, surgery, and patch test appointments. If you are more than 10 minutes late for your appointment, we will attempt to accommodate you during that session, however there is no guarantee, and the appointment may need to be rescheduled to another day.

DMG

Patient Name: _____ Date: _____

Were you referred by a Physician? If yes, by who? _____

Primary Care Physician: _____

Tobacco use? (circle answer below)
Never used
Former user
Current user

For Patients 65 years or older:

Do you have an advanced directive?	Yes	No
Do you have a medical power of attorney?	Yes	No
If yes, is it currently in effect?	Yes	No
If yes, please list name of acting medical power of attorney:		

#83 MIPS 6/23

DETAILED VOICEMAILS

Would you like DMGNC's staff to leave a detailed voice message on your preferred phone number?

This may include information such as appointment details, prescription refill status, test/labs/procedure results, and/or insurance authorization information.

Yes_____ No_____ If yes, please confirm you preferred number: _____

Signature_____ Date_____

DERMATOLOGIST MEDICAL GROUP OF NORTH COUNTY, INC.

Zubair Durrani, Privacy Officer 760-758-5340

I hereby acknowledge that I have received a copy of Dermatologist Medical Group's Notice of Privacy Practices. I understand that a copy of the notice is posted in the reception area and has been made available on the practice website, www.dmgnc.com/patient-forms. I further understand that a copy of any amended Notice of Privacy Practices will be available at each appointment.

_____	_____	_____	_____
Signature	*Date*	*Print Name*	*Telephone*

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

At Dermatologist Medical Group of North County, we take patients' privacy very seriously and follow all HIPAA rules and regulations. HIPAA prohibits us from unauthorized disclosure of patient's information. If you would like us to share your health-related information with a family member or friend, you must provide written consent. The consent provides Dermatologist Medical Group the ability to share appointment details, billing information, test and procedure results to those you have listed. If you do not wish to share your health information with anyone, please write "N/A" and sign on the signature line.

You have the right to revoke or make changes to this consent at any time. Any amendments must be made in writing and signed.

By signing below, you authorize Dermatologist Medical Group of North County, Inc. to release the above mentioned information to the following individuals:

_____	_____	(_____)_____	___/___/___
Name	*Relation to Patient*	*Telephone*	*Date of Birth*
_____	_____	(_____)_____	___/___/___
Name	*Relation to Patient*	*Telephone*	*Date of Birth*

_____

Signature of Patient, or Personal Representative ***Date***

_____

If Personal Representative, Relationship to Patient

DERMATOLOGIST MEDICAL GROUP OF NORTH COUNTY, INC.

History and Intake Form

Past Medical History: (Please circle all that apply)

Anxiety	Depression	Hypothyroidism
Arthritis	Diabetes	Leukemia
Asthma	End Stage Renal Disease	Lung Cancer
Atrial Fibrillation	GERD	Lymphoma
BPH	Hearing Loss	Prostate Cancer
Bone Marrow Transplant	Hepatitis	Radiation Treatment
Breast Cancer	Hypertension (high blood pressure)	Seizures
Colon Cancer	HIV/AIDS	Stroke
COPD	Hypercholesterolemia (high cholesterol)	**NONE**
Coronary Artery Disease	Hyperthyroidism	Other:

Skin Disease History: (Please circle all that apply)

Acne	Melanoma
Actinic Keratosis	Poison Ivy
Basal Cell Carcinoma	Precancerous moles
Blistering sunburns	Psoriasis
Dry Skin	Rosacea
Eczema	Squamous cell carcinoma
Flaking or itchy scalp	NONE
Hay fever/ allergies	Other:

Past Surgical History: (Please circle all that apply)

Breast Implants	Heart: Transplant	Skin: Basal Cell Cancer Surgery
Heart: Biological Valve Replacement	Joint Replacement: Knee (Right, Left, Bilateral)	Skin: Melanoma Surgery
Heart: Coronary Artery Bypass	Joint Replacement: Hip (Right, Left, Bilateral)	Skin: Squamous Cell Carcinoma Surgery
Heart: Mechanical Valve Replacement	Joint Replacement within last 2 years	Other:
Heart: Pacemaker	Kidney: Transplant	

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:

_____

_____

DMG

Patient Medication List

Pharmacy Information: (Please provide as much information as possible)
Pharmacy Name: _____
City: _____ Zip Code: _____
Phone Number: _____

ALLERGIES: (please list all DRUG allergies)

_____
_____
_____

Please list any Medications you are taking including any over the counter vitamins and supplements:

Medication Name	Strength (ex. *50mg*)	Frequency *(once a day)*	Route of administration (ex. orally)

DERMATOLOGIST MEDICAL GROUP OF NORTH COUNTY, INC.

NOTICE AND ACKNOWLEDGMENT OF RECEIPT AND UNDERSTANDING

NOTICE TO PATIENTS

The Open Payments database is a federal tool
used to search payments made by drug and device companies
to physicians and teaching hospitals.

It can be found at

https://openpaymentsdata.cms.gov.

Medical doctors are licensed and regulated
by the Medical Board of California.

To check up on a license or to file a complaint go to

www.mbc.ca.gov,

email: licensecheck@mbc.ca.gov,

or call (800) 633-2322.

By signing below, I certify I have received a copy of this notice.

Patient's Name (print)	Patient's Signature	Date
Patient Representative's Name And Relationship (print)	Patient Representative's Signature	Date