Alamitos Dermatological Medical Clinic, Inc.
(dab: Coastal Dermatology and Plastic Surgery)

Patient

Social Security Number: _____-_____-_____

Patient Last Name: _____First Name: _____ MI: _____ Title: _____ Birth date: _____ Age: _____

Street: _____ City:_____ St: _____ Zip code:_____

Home Phone: _____Cell Phone: _____ Sex: ____ Marital: _____ Driver Lic:_____

E-mail:_____ Alt Phone:_____ Spouse:_____

Employer: _____ Occupation: _____ Work Phone: _____ Ext: ____

Responsible Party

Patient's Relationship to Insured: _____ SS# of Insured: ____ _____ Home/Cell Ph: _____

Insured Last Name: _____First Name: _____ MI: _____ Title: _____ Birth date: _____ _____

Insured Street: _____ City: _____ St: _____ Zip code:_____

Nearest Relative Outside of Home

Name: _____ Relationship: _____ Hm Phone: _____ Cell Ph: _____

Street: _____ City:_____ St: _____ Zip code:_____

Primary Insurance

Insurance Carrier: _____ Eligible From: _____ ID#:_____ Group # _____

Secondary Insurance

Patient's Relationship: _____ Insured Last Name: _____First Name: _____ MI: _____

Insurance Carrier: _____ Eligible From: _____ ID#:_____ Group # _____

Supplemental Insurance

Insurance Carrier: _____ Eligible From: _____ ID#:_____ Group # _____

Supplemental Insurance

Any **ALLLERGIES** to Medications? (If so, list all): _____

Are you a **STUDENT**? (If so, please provide a copy of your student ID) Yes_____ No_____

Who **REFERRED** you or how did you find us? (PPO Directory/ Yellow Pgs/Ad/ Yelp/ etc.): _____

Referring Doctor: _____ Relative: _____ Friend: _____Internet:_____

Authorization to Release Information and Assignment of Benefit

I hereby assign all medical, and or surgical benefits, for insurance to Alamitos Dermatological Medical Clinic, Inc. A photocopy of this assignment is to be considered as valid as the original. I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release all necessary information to secure payment. **Please remember all balances over 90 days old will be subject to a 15% monthly surcharge.**

Print Name: _____ Signature: _____ Date:_____

Alamitos Dermatological Medical Clinic, Inc.

Matthew B. Luxenberg M.D. | **Michael R. Arnstein M.D.**

Sidney B. Newman M.D. | **Michael A. Radonich M.D.**

Charles D. Rosenberg M.D. | **Jung "Anne" Sung PA-C**

HIPPA PRIVACY REGULATIONS

Notification is therefore given that the office of Alamitos Dermatological Medical Clinic, Inc. dba Coastal Dermatology & Plastic Surgery, and its affiliated physicians, will not reveal any personal information about you and /or your family member (i.e. name, address, social security number as well as health information) without permission. Your information will never be sold to list for the purpose of advertisement, solicitation, or fund raising.

It is however, understood, that within the realm of doing business and for general patient care purpose, your personal information will be necessary and used in the following context:

- Patient Registration
- Procure medical records from former physicians
- Converse with colleagues for opinions/care
- Insurance; Verification, billing, paper and wire (including fax transmissions).
- Insurance company follows up or interaction with billing services relation to patient care.
- Pursue collection of unpaid bills
- Hospital workers, nurse, aids and medical records department
- Emergency officials, paramedics, fire personnel, emergency room physicians, nurses or technicians
- Personal Religious Designate
- Pharmacist, drug program personnel/workers
- Completions of disability forms
- Computer and electronically stored information (i.e. related business vendor and service persons)

I authorize the release of this necessary information

_____ _____

Patient's Signature Date

(562) 598-8593
3801 Katella Ave. #425
Los Alamitos, CA 90720

(714) 842-7796
17822 Beach Blvd.,#427
Huntington Beach, CA 92647

(949) 581-1588
27725 Santa Margarita Pkwy #110
Mission Viejo, CA 92691

(714) 838-5680
12721 Newport Ave #4
Tustin, CA 92780

REFFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name:_____ Today's Date_____/____/_____

Other family members that are patients: _____

Referred by: _____

EMERGENCY CONTACT INFORMATION

In case of Emergency who should be notified_____ Phone ( ) _____

Relationship to patient: _____

Do you give our office permission to discuss your medical information with family members?
____ YES ____ NO If yes, please provide their names and phone numbers below

Name: _____ Relationship: _____

Phone # (day): (_____) _____ Phone# (evening): (_____) _____

May we leave personal medical information on your answering machine of cell phone? _____ YES _____NO

May we e-mail persona medical information to you? _____ YES _____NO

E-mail address_____

RECEIPT OF NOTICE OF PROVACY PRACTICES:

My signature below indicates that I have received and /or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature _____ Date_____/____/_____

PAYMENT POLICY:

HMO, PPO or other managed care patients: You will be responsible for paying your annual deductible, co payment and charges for any non-covered, cosmetic services at the time of service.

Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 50% of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patient or Responsible Party Signature _____
Date ____/_____/_____

Medical History

Patient: _____ Date: _____/_____/_____

Reason for today's visit: _____

Are you allergic to any medications? □ Yes □ No If yes, please list:_____

List all medications you are currently taking (include prescriptions, over the counter meds, vitamins, and herbals):

_____

_____

Do you have now, or have you ever had diseases or conditions of: *(If yes, please check the boxes that correspondto you.)*

Lungs:
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Asthma
- ☐ Chronic Cough
- ☐ Morning Cough
- ☐ Shortness of Breath
- ☐ Wheezing

Cardiovascular:
- ☐ High Blood Pressure
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Irregular Heartbeat
- ☐ Pacemaker
- ☐ Phlebitis
  - ☐ Inflamation of Vein
  - ☐ Blood Clots

Other Systemic:
- ☐ Diabetes
  - ☐ Excessive thirst/hunger
- ☐ Thyroid
- ☐ Kidney
- ☐ Dialysis
- ☐ Bladder
  - ☐ Frequency/ Burning

Gastrointestinal:
- ☐ Stomach absorptive disorder
- ☐ Nausea, vomiting, diarrhea (when taking anibiotics)
- ☐ Yeast Infection (when taking antibiotics)
- ☐ Arthritis/ Joint Deformity
- ☐ Arthragalia
- ☐ Limited Motion
- ☐ Artificial Joint
- ☐ Convulsions/ Eplilepsy/ Seizures
- ☐ Fainting

List any other diseases or conditions:_____
List Surgical procedures you have had in the last 6 months:_____

Skin: Have you ever had skin cancer?
Has anyone in your family had skin cancer?
Do you have history of any specific skin disease?
Do you have problems hearing?
Do you develop keloid (scars) after surgery?
Do you bleed easily?
Do you develop skin rashes in reaction to □Medications □Food □Enviroment □Bandages □Topical Neosporin □ Other:_____

Social History:
Do you drink alcohol? □ Yes □ No If yes, ____ drinks per day
Do you use IV drugs? □ Yes □ No If yes, What?_____ How Often?_____
Do you Smoke? □ Yes □ No If yes, how much?_____
Have you had or have been exposed to HIV (AIDS)? □ Yes □ No
Please answer the following question (Women) Are you pregnant? □ Yes □ No Due Date: _____/_____/_____

Completed by: □ Patient □ Medical Assistant Medical Assistant Initials: _____

Patient Signature: _____ Date:_____ Reviwed By:_____