

## Dermatology New Patient History

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Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Referred by \_\_\_\_\_ Primary MD \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Reason for Visit \_\_\_\_\_

Duration of Problem \_\_\_\_\_

Treatments Used \_\_\_\_\_

**Do you have a History of any of the following? (check yes or no):**

	Yes	No		Yes	No		Yes	No
High Blood Pressure			Diabetes			Artificial Heart Valve		
Heart Attack			Liver Disease			Joint Replacement		
Heart Arrhythmia			Lung Disease			Bleeding Disorder		
Heart Murmur			Kidney Disease			Poor Wound Healing		
Heart Pacemaker			Asthma			Poor Surgical Results		
Congestive Heart Failure			Cancer			Reaction to Local Anesthetic		
Angina			Hepatitis			Do You Smoke		
Seizure Disorder			HIV infection			Do You Drink Alcohol		

**Please list the following information (or write none):**

Any Other Medical Problems \_\_\_\_\_

Operations/Surgeries \_\_\_\_\_

Medicines You Are Taking \_\_\_\_\_

Drug Allergies \_\_\_\_\_

Family History of Medical Problems \_\_\_\_\_

Signature \_\_\_\_\_ Today's Date \_\_\_\_\_

Nurse \_\_\_\_\_ Physician Review \_\_\_\_\_

# Dermatology Patient Registration Sheet

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Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex: M F Marital Status: S M DP D W

Social Security Number \_\_\_\_\_ Driver's License Number \_\_\_\_\_

Local Address \_\_\_\_\_

Number

Street

Apt. #

City

State

Zip Code

Phone Numbers: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Home/Local Secondary Emergency/Other

Secondary Address \_\_\_\_\_

Number

Street

Apt. #

City

State

Zip Code

E-Mail Address \_\_\_\_\_

Employer & Address \_\_\_\_\_

Referring Physician \_\_\_\_\_

Medicare Number \_\_\_\_\_

Medicare Supplement \_\_\_\_\_ Group/Policy # \_\_\_\_\_

MediCal Number \_\_\_\_\_

Private Insurance \_\_\_\_\_ Group/Policy # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insured's SSN \_\_\_\_\_ Employer Name \_\_\_\_\_

Employer Address and Phone \_\_\_\_\_

Signature \_\_\_\_\_ Today's Date \_\_\_\_\_

(See reverse side)

## Consent for Treatment and Authorization for Insurance Payment

*All patients, please initial and sign below*

\_\_\_\_\_My initials and signature below are indication of my general consent and authorization, for this and subsequent visits, for evaluation and treatment at Mirage Dermatology including the taking of appropriate history, physical exam, and other tests or procedures necessary for my medical care.

\_\_\_\_\_My initials and signature below also authorize Mirage Dermatology, or its agent, to release to my insurance company(ies), any or all medical records in its possession, necessary for claims review and adjudication, for this and subsequent visits. I also authorize payment of medical benefits from my insurance company(ies) directly to Mirage Dermatology. I permit a copy of this authorization to be used in place of the original.

\_\_\_\_\_My initials and signature below indicate my understanding that payment by my insurance may not represent full payment for services rendered, and that I will be responsible for the balance due as allowed by my insurance carrier.

\_\_\_\_\_My initials and signature below acknowledge that I have received a copy of Mirage Dermatology's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment. I also understand that I may contact the privacy officer (Office Manager) with any questions about this Notice at (760) 341-1999.

*Medicare patients only, please initial and sign below*

\_\_\_\_\_My initials and signature below authorize Mirage Dermatology, or its agent, to release to the Centers for Medicare and Medicaid Services, Social Security Administration, and Medicare (or its intermediaries or carriers) any and all medical information needed for this or subsequent Medicare claims. I request that payment of medical insurance benefits be made directly to Mirage Dermatology. I permit a copy of this authorization to be used in place of the original.

\_\_\_\_\_My initials and signature below authorize Mirage Dermatology, or its agent, to release to my Medigap ("secondary insurance") carrier any and all medical information needed for this or subsequent claims. I also request that payment of medical insurance benefits from my Medigap ("secondary insurance") be made directly to Mirage Dermatology. I permit a copy of this authorization to be used in place of the original.

Signature\_\_\_\_\_Today's Date\_\_\_\_\_