

Dermatology New Patient History

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

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) 324-4400.

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_____