


Patient Name/Date of Birth: _____	 HEALTH QUESTIONNAIRE
Email: _____	

Referring physician	Primary care physician
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Why are you seeing the dermatologist today? _____

What prior treatments have you used for this condition? _____

What part(s) of your body is (are) affected? _____

How long have you had the problem? _____

Has this problem resulted in: itching bleeding infection open wound

Are you having any pain associated with the reason for your visit today? Yes No

Describe the pain burning stabbing sharp numb unable to describe

Location of the pain _____

How long have you had the pain? _____

How often does it occur? _____

Past Personal Skin problems	Family History of Skin problems
<input type="checkbox"/> Abnormal moles <input type="checkbox"/> Melanoma <input type="checkbox"/> Skin cancer (other)-specify type <input type="checkbox"/> Eczema or dermatitis <input type="checkbox"/> Psoriasis	<input type="checkbox"/> Connective tissue disease <input type="checkbox"/> Blistering disorders <input type="checkbox"/> Thick scars or keloid <input type="checkbox"/> Other – specify: _____
<input type="checkbox"/> Melanoma <input type="checkbox"/> Skin cancer (other)-specify type <input type="checkbox"/> Eczema or dermatitis <input type="checkbox"/> Psoriasis <input type="checkbox"/> Connective tissue disease <input type="checkbox"/> Other – specify: _____	

List all known allergies and intolerances: _____ **If none, check here**

List all current medications (including non-prescription and vitamins): _____

Do you have to take antibiotics before routine dental procedures: Yes No

Do you have any of the following conditions:

<input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Artificial heart valve <input type="checkbox"/> Artificial joints <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding disorders <input type="checkbox"/> Cancer _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy	<input type="checkbox"/> Glaucoma <input type="checkbox"/> Gout <input type="checkbox"/> Heart disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Herpes <input type="checkbox"/> High cholesterol <input type="checkbox"/> High blood pressure <input type="checkbox"/> HIV infection/AIDS <input type="checkbox"/> Kidney disease <input type="checkbox"/> Liver disease	<input type="checkbox"/> Osteoporosis <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Sexually transmitted disease <input type="checkbox"/> Sores in mouth <input type="checkbox"/> Stomach ulcer <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Tuberculosis <input type="checkbox"/> None of the above
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Continued on the back →

What is your occupation?
What are your hobbies?
Habits Alcohol (Amount per week): _____ Tobacco (Amount per week): _____ Aspirin (Number per day): _____
Women Only Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you trying to become pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Are your menstrual periods regular? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Postmenopausal Birth control method: _____

CONSENT AND AUTHORIZATION FOR TREATMENT

By my signature below, I authorize evaluation and treatment by the doctors and the Dermatology Institute of Southern California. I understand that dermatology is an inexact science and many conditions are chronic and require ongoing care. All medications have potential side effects and there are risks to any medication prescribed.

Dermatologists frequently treat skin growths by freezing, cauterization with a heated needle, excision by cutting the lesion out, and/or cortisone injections. I understand that there are risks to any procedure performed on the skin and that these risks include, but are not limited to, permanent discoloration of the skin, scarring, pain, infection, bleeding, and/or nerve damage. I consent to having these procedures as part of my treatment.

I understand that full skin examinations for cancer screening are performed if scheduled in advance. I recognize that most visits to the office are for consultation, and evaluation, and that surgeries, even minor removals, need to be scheduled at a separate time. This authorization and consent shall remain in force for all future visits to this office.

PRIVACY PRACTICE ACKNOWLEDGEMENT:

By signing below, I further acknowledge that I have been provided an opportunity to review the notice of privacy practices.

Patient Signature _____ Date _____

Physician Signature _____ Date _____



Not Interested, Thank you

Cosmetic Questionnaire

If you are interested in any of our cosmetic procedures, please take a moment to complete this questionnaire.

- | | | | |
|--------------------------|-----------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | Acne or Acne Scarring | <input type="checkbox"/> | Laser Resurfacing |
| <input type="checkbox"/> | Age Spots | <input type="checkbox"/> | Rosacea or Broken Capillaries |
| <input type="checkbox"/> | Botox Cosmetic | <input type="checkbox"/> | Skin Care Products |
| <input type="checkbox"/> | Cosmetic Fillers | <input type="checkbox"/> | Skin Elasticity |
| <input type="checkbox"/> | Chemical Peels | <input type="checkbox"/> | Spider Vein Treatments |
| <input type="checkbox"/> | Excessive Sweating | <input type="checkbox"/> | Sun Damage and Prevention |
| <input type="checkbox"/> | Hyperpigmentation / Melasma | | |

What are your major areas of concern, or where would you like to see improvement?

Have you used skin care products to treat this problem/concern?

Are you interested in speaking to our aesthetician about skin care products and aesthetic procedures?

YES

NO

Please note any additional concerns or questions that you may have:



PATIENT-PHYSICIAN AGREEMENT

Thank you for selecting The Dermatology Institute of Southern California for your medical care. We look forward to assisting you with your health needs. In order to prevent any misunderstanding concerning your medical care, including the responsibility for payment for medical and surgical services provided to our patients, the following information is supplied:

The patient is responsible for assisting the physician with management of the patient's healthcare needs. This includes maintaining compliance with diagnostic and treatment recommendations. The patient or his/her guarantor is responsible for payment of services provided by the Dermatology Institute of Southern California at the time of service. The only exception is if The Dermatology Institute of Southern California has contracted with your insurance company to accept the insurance payment as payment in full after all deductibles have been met and co-payment has been paid. Tests run in the office or which are referred to an outside facility, such as pathology, laboratory, radiology, or other diagnostic tests may be billed separately and will be in addition to the office visit charges.

The Dermatology Institute of Southern California charges a cancellation charge for appointments canceled with less than 24 hours notice as well as for not showing up for an appointment. Charges may apply for telephone consultations and/or e-mail consultations.

HMO/PPO or Contracted Insurance Coverage.

If you have insurance coverage through a company that we have contracted with, we require a copy of your insurance card and driver's license (or other photo identification), your mailing address and payment of your co-payment at the time of service. An additional billing fee may be charged for co-payment not paid at the time of service. If your annual deductible for the calendar year has not been met, you will be responsible for any charges incurred payable at the time of service.

Please be aware that your health insurance policy is an agreement between you and your insurance company. All charges are your responsibility, whether or not you have insurance. Not all services are covered under all contracts. Because there are so many different insurance plans, it is not possible for us to know the specific details of your coverage. Keep in mind that care your doctor believes is medically necessary may not be considered to be a "medical necessity" under your insurance plan. In some cases, your doctor might decide that you need medical care which is not covered by your insurance policy.

Medicare

Our physicians are participating Medicare providers. Office visits with a doctor are covered under Part B of the Medicare program. Medicare pays 80% of their allowable charges after you pay your annual deductible for the calendar year, and you are responsible for paying the other 20%. If you have supplemental insurance, we require a copy of your insurance card and insurance mailing address. We are not contracted with Medi-cal.

Authorization to Perform Lab Tests

With respect to medical care and services provided and to be provided by The Dermatology Institute of Southern California and physicians providing Medical and Professional services it is agreed and understood: I hereby give The Dermatology Institute of Southern California authorization to perform the required laboratory or pathology test(s) that have been ordered by the doctor. Depending on your insurance, you may be billed separately from your office visit by the lab. Some insurance companies may require you to use a particular lab or hospital for tests. You may then choose to pay for your own lab tests, or go to the laboratory/hospital where your insurance requires that you go. I hereby certify that I have been notified by The Dermatology Institute of Southern California about the name, address and charges of the laboratory performing these tests. I also understand these bills may or may not be combined with the office visit. Furthermore I understand that extra charges will be added to the charges of Laboratory for professional interpretation by the physician and handling fees.

Billing and Collections Policy

You will receive a statement after your insurance company has processed your claim. If your full balance is not paid within 30 days of receipt of our statement, you will be charged a finance charge amounting to a 18% annual percentage of the unpaid balance on your account (which corresponds to a monthly periodic rate of 1.5%). If payment in full is not received 30 days after the date of your second statement, your account will be automatically forwarded to a collections agency for further action. Any accounts forwarded to the collections agency become the property of the collection agency and are subject to additional fees as allowed by law. Any balances that your insurance carrier has not acted upon within 45 days will be transferred to your responsibility.

I have read all the information above and agree that, regardless of my insurance status I am ultimately responsible for the balance of my account for any professional services rendered.

In the event that my insurance company is billed, I authorize payment of medical benefits to be paid directly to The Dermatology Institute of Southern California. I authorize the release of any medical information necessary to process my claims. A photocopy of this agreement shall be considered as effective and valid as the original.

Patient name: _____

Name of responsible party (if other than patient): _____

Signature of patient/responsible party: _____ Date: _____