Patient Registration

(Please Print)

Date: ____________

Patient: ______________________________________ Birthdate: ___/___/___ Age: _____
(First) (Middle) (Last)

Home Address: ______________________________________ Home Phone: (___)____________
(Street) (Apt. #)
Cell Phone: (___)____________

______________________________________ Work Phone: (___)____________
(City) (State) (Zip Code)

Email : ________________________

Sex: ____ Driver's Lic. #: _______________ Marital Status: __________ Spouse Name: _________________

Soc. Sec.#: __________________________ Employer Name: ______________________________________

Employer Address: ____

Employer Phone #: (___)______________ Occupation: ____

Referred By: ____

Responsible Party Information

(If Minor)

Name: ____________________________ Relationship: _____________ Soc. Sec. #: ____________________

Home Address: ______________________________________ Home Phone: (___)____________
(Street) (Apt. #)
Cell Phone: (___)____________

______________________________________ Work Phone: (___)____________
(City) (State) (Zip Code)

Email : ________________________

Employer Name: ____ Occupation: ___________________

Employer Address: ____

May we leave a message on your home answering machine? ☐ Y ☐ N

May we leave a message for you at work to call us? ☐ Y ☐ N

May we discuss your medical condition with another person? ☐ Y ☐ N

If yes, whom _______________________________________ Relationship ____________________________

In Case of Emergency, You May Contact:

Name: ____ Relationship: _______________________

Address: ____ Phone: (___)______________

All charges are the direct responsibility of the patient. Payment is due at the time services are rendered. I hereby authorize the release of my medical information, if necessary, to process a claim or for further treatment or care by physicians.

Patient's Signature: ____ **Date:** ______________________
(Parent / Guardian If Patient Is a Minor)

For Contracted Insurance Patients: I hereby assign my insurance benefits to be made directly to my physician and any assisting physician for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member. I understand that I am responsible for knowing my benefits / coverage. I will be financially responsible for all charges that are not covered by my insurance company.

Patient's Signature: ____ **Date:** ______________________
(Parent / Guardian If Patient Is a Minor)

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PLEASE PRESENT THIS FORM WITH YOUR INSURANCE CARD AND DRIVER'S LICENSE TO THE RECEPTIONIST

1401 Avocado Avenue, Suite 703, Newport Beach, CA 92660
Tel: 949 760 0190 Fax: 949 760 0439

HOW DID YOU HEAR ABOUT US?

DOCTOR ☐
PLEASE LIST DOCTOR'S NAME AND ADDRESS:

FRIEND ☐
PLEASE LIST NAME AND ADDRESS:

NEWSLETTER ☐

WEB SITE ☐

☐ Silverberg web site
☐ Google
☐ Yahoo
☐ Other

OTHER ☐

☐ Daily Pilot Newspaper
☐ Orange County Register
☐ OC Magazine
☐ Yellow Pages
☐ Other:

Medical Information

(PLEASE PRINT)

I Medical History

Do you have or have you ever had:

	Yes	No
Heart Attack / Angina	☐	☐
Heart Murmur	☐	☐
Artificial Heart Valve / Joint	☐	☐
High Blood Pressure	☐	☐
Dizziness / Fainting Tendency	☐	☐
Pacemaker	☐	☐
Frequent or Severe Headaches	☐	☐
Epilepsy / Stroke	☐	☐
Bleeding Problems	☐	☐
Anemia or Blood Disorder	☐	☐
Abnormal Response to Cold	☐	☐
Poor Wound Healing	☐	☐
Skin Pigment Problems	☐	☐
Keloids or Abnormal Scars	☐	☐
Diabetes	☐	☐
Thyroid Condition	☐	☐
Kidney or Bladder Problems	☐	☐
Hepatitis / Liver Disease	☐	☐
Aids / HIV Positivity	☐	☐
Fever Blisters / Cold Sores	☐	☐
Tuberculosis	☐	☐
Stomach Ulcers	☐	☐
Sinus or Hay fever	☐	☐
Glaucoma	☐	☐
Asthma	☐	☐
Depression / Mental Illness	☐	☐
Cancer: Type? ___________________	☐	☐
Radiation Treatment: Site? __________	☐	☐
Are You Pregnant? Nursing?	☐	☐
Under Medical Treatment Now?	☐	☐

II Medications

Are you sensitive or allergic to:

	Yes	No
Penicillin	☐	☐
Local Anesthetic	☐	☐
General Anesthetic	☐	☐
Any Other Medication or Foods	☐	☐

If So, What? ____________________________

____

Are You Taking:

Aspirin	☐	☐
Cortisone, Prednisone, Steroids	☐	☐
Anti coagulates / Blood Thinners	☐	☐
Tranquilizers or Sedatives	☐	☐
Insulin	☐	☐
Any Other Medications or Drugs	☐	☐

If So, Specify ___________________________

____

III Family History

Skin Cancer	☐	☐
Dysplastic Nevi (Moles)	☐	☐
Other Skin Disorder	☐	☐

If So, Specify ___________________________

____

IV Past Medical History

Type or Name **Year** **Local / General Anesthesia**

Operations: ____

____

Illnesses: ____

____

V Social History

Approximately Daily Consumption of: Alcohol ____________ Tobacco ____________ Coffee ____________

VI Have you ever seen a Dermatologist? _____ Yes _____ No Dr. __________________ Date _____________

(If you would like us to request your records, please request a records release form.)

Form Completed By: ____ Date: ___________________

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NOTICE OF PRIVACY PRACTICES

This notice describes how information about you as a patient of this practice may be used and disclosed, and how to access your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

The following circumstances may require us to use or disclose your health information:

1. **To provide treatment:** We will use your health information within our office to provide you with the best health care possible. This may include administrative and clinical office procedures to schedule and coordinate care between physician, technician, nurse, and business office staff. In pathology laboratories, pharmacies or other health care personnel providing your treatment. It may be necessary to release your test results to authorize health care providers treating patients even when the provider requesting the results did not originally order the tests.
2. **To obtain payment:** We may include your health information with an invoice used to collect payment for treatment you received in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will make every attempt to work only with companies with similar commitment to the security of your health information.
3. **To conduct health care operations:** Your health information may be used during performance evaluations of our staff, during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.
4. **Communications:** Because we believe regular follow up is very important to your health, we may remind you of a scheduled appointment or that it is time for you to contact us to make an appointment. These communications may include postcards, letters, and telephone reminders. WE may share your health information with those you tell us will be helping you with your home treatment, medications, or payment. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may request that we contact you at home, rather than work. We ill try to accommodate reasonable requests.
5. **Required by law:** We may disclose your health information to public health authorities and health oversight agencies that are authorized by law to collect information, when required to do so by a law enforcement official, lawsuits and similar proceeding in response to a court or administrative order, when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public, for Worker's Compensation and similar programs.

Our patient medical records are kept confidential, secure, and out of reach by unauthorized persons. All reports, consultation and correspondence are reviewed by the physician prior to being filed in the medical records. A written released signed and dated by the patient/guardian must be obtained prior to the release of medical record information.

You are entitled to receive a copy of this Notice of Privacy Practices.

I____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of protected health information to carry out treatment, payment activities, and health care operations and laboratory testing.

Signature:____Date:____________________
(Parent/guardian if patient is a minor)

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PATIENT FINANCIAL POLICY

This office has contracts with Medicare and with many managed care plans. Please check with our front office staff to determine whether your plan is one of these.

If we have a contract with your plan, we will file a claim with your insurance company. The amount for which you are responsible (any deductibles, copays, percentages or non-covered services) is required at the time of service.

If you do not have one of the plans with which the practice is contracted, the total cost of your visit is required at the time of service.

If at any time you are concerned about the cost of a procedure proposed by the doctor, you may ask for someone from the business office who will be happy to discuss the cost with you.

For your convenience in paying, this office accepts credit & debit cards in addition to cash and checks.
I certify that I have read the Silverberg Surgical & Medical Group Financial Policy and agree to abide by the policy.

Signature_______________________________________Date___________________

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WAIVER FOR COSMETIC PROCEDURES

Physician notice

Your insurance carrier will pay only for dermatologic services that are designed to treat an illness or injury. Your carrier does not cover some or all of the services we render because they are cosmetic in nature.

Beneficiary agreement

I have been notified by my physician that my insurance carrier will not cover some or all of the services rendered for the reason stated above. Since I have been notified in advance of this determination, I agree to be personally and fully responsible for payment for services rendered by my physician.

I understand that my doctor will not file a claim for any service considered to be cosmetic.

I understand and agree that the charges for any cosmetic service must be paid in full by me.

_______________________________________   ______________________
Beneficiary signature   Date