



**PATIENT INFORMATION FORM**

Patient's Name \_\_\_\_\_  
Last First Middle

Home Address \_\_\_\_\_  
Street \_\_\_\_\_  
City State Zip Code

**(PLEASE DO NOT PUT A P.O. BOX)**

Mailing Address (if different from above)

\_\_\_\_\_ Street \_\_\_\_\_  
\_\_\_\_\_ City State Zip Code

Sex \_\_\_\_\_

Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_  
Street \_\_\_\_\_

\_\_\_\_\_ City State Zip Code  
Home Phone ( ) \_\_\_\_\_ Work Phone( ) \_\_\_\_\_

Date of birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_ Social Security # \_\_\_\_\_

Driver's License# \_\_\_\_\_ State \_\_\_\_\_ Marital Status \_\_\_\_\_

**Name of Parent and/or Legal Guardian if Patient is a Minor**

\_\_\_\_\_  
Date of birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security # \_\_\_\_\_

Driver's License# \_\_\_\_\_ State \_\_\_\_\_ Marital Status \_\_\_\_\_

Insured Name \_\_\_\_\_ Insured Birthday \_\_\_\_\_

Insured Employer's Address \_\_\_\_\_  
\_\_\_\_\_

Employer's Phone \_\_\_\_\_

**Please present your insurance cards and photo ID (driver's license) to the receptionist so copies can be made.**

Primary Insurance \_\_\_\_\_ Policy/Group# \_\_\_\_\_

Insured Social Security # \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Policy/Group# \_\_\_\_\_

Insured Name \_\_\_\_\_ Insured Birthday \_\_\_\_\_

Insured Social Security # \_\_\_\_\_

Referred by: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

In case of emergency, who should be notified?

\_\_\_\_\_  
Name Phone Number

Relationship to Patient \_\_\_\_\_

Do we have your permission to:

Leave a message on your answering machine?  Yes  No

Leave a message at your place of employment?  Yes  No

Discuss your medical condition with any member of your family?  Yes  No

If yes, whom \_\_\_\_\_ Relationship \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

I authorize the release of medical information to my primary care referring physician, to consult if needed and as necessary to process claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician.

\_\_\_\_\_  
Patient or Responsible Party Signature Date



## Patient Financial Policy

In order to reduce confusion and misunderstanding between our patients and the practice, Bayview Dermatology and Laser Medical Center, Inc. ("Bayview Dermatology") has adopted the following financial policy. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. If you have any questions about the policy, please discuss them with our office manager.

**As a patient of Bayview Dermatology, I hereby understand and agree to the following:**

**Please Initial Each Paragraph,**

\_\_\_\_\_ I am financially responsible for all charges concerning my care and treatment. My insurance policy is a contract between my insurance company and me and does not involve Bayview Dermatology. For my convenience, Bayview Dermatology will accept Visa, MasterCard, American Express and Discover, check or cash.

\_\_\_\_\_ Full Payment is due at the time of all services including services such as cosmetic consultations and procedures. As a courtesy, Bayview Dermatology may forgo requiring my complete payment at the time of service, if the following conditions are met:

- 1) In advance of my appointment, I provide Bayview Dermatology my current medical insurance information and Bayview Dermatology has had the opportunity to verify said coverage and make copy of my insurance card and driver's license;  
and
- 2) Bayview Dermatology has made prior arrangements with my insurance company to accept an assignment of benefits;  
and
- 3) The service provided by Bayview Dermatology is considered a "covered" service by my insurance company;  
and
- 4) I agree to have my insurance company pay Bayview Dermatology directly and assign my insurance benefits to Bayview Dermatology;  
and
- 5) At the time of service, I provide complete payment of any authorized deductible, co-insurance or co-payment;  
and
- 6) I understand and agree that if my insurance company does not pay Bayview Dermatology within 30 days, I am responsible to provide Bayview Dermatology payment in full and that if I receive a statement from Bayview Dermatology, payment is due immediately upon receipt of that statement. An interest rate of 18% will accrue monthly on any unpaid balances.

\_\_\_\_\_ I understand and agree that if I have insurance coverage with a plan that does not have a prior agreement with Bayview Dermatology, complete payment for my care and treatment is due at the time of the service. Bayview Dermatology will prepare and send the claim for me on an unassigned basis. This means that my insurer will send the payment directly to me.

\_\_\_\_\_ I am responsible for obtaining any necessary referrals prior to my appointment. If I do not present Bayview Dermatology with any necessary referral prior to my appointment, I am responsible for payment in full.

\_\_\_\_\_ **HMO'S are NOT accepted.** When billing for Aetna Managed Choice plan, Bayview Dermatology will bill as "point of service." Any multilevel insurance plan will also be billed as "point of service" or "PPO" and any co-payments, co-insurances and deductibles will be collected at the time of service.

\_\_\_\_\_ All health plans are not the same and do not cover the same services. I understand and agree that in the event my health plan determines a service is "not covered," I am responsible for the complete payment of the service at the time of service.

\_\_\_\_\_ I understand and agree that for all service rendered to minor patients, Bayview Dermatology will look to the adult accompanying the patient and the parent or guardian with custody for payment.

\_\_\_\_\_ I understand and agree that my appointment time is reserved especially for me and that Bayview Dermatology requires that I give a **24-hour notice (NOT INCLUDING WEEKENDS)** if I need to reschedule my appointment. I further understand and agree that a \$100.00 fee (not payable by insurance) will be charged to me for each 15-minute time slot (a surgical appointment is 30 minutes) I miss or cancel without 24-hour notice. **Attention Moh's surgical patients we require a 48-hour notice of cancellation (NOT INCLUDING WEEKENDS) so we may try to accommodate another patient for surgery.**

\_\_\_\_\_ I understand and agree that a \$25.00 service fee for the first returned check and \$35.00 per check for each subsequent check (not billable to insurance) will be charged for the return checks, including non-sufficient funds and/or stop payment checks. The writing of "bad" checks is against the law and violates California Civil Code Section 1719. I understand and agree that I can be charged three times the amount of any "bad" check I provide to Bayview Dermatology and any court costs incurred to obtain payment. In accordance with California State Law.

**I have read and understand the financial policy of Bayview Dermatology and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.**

\_\_\_\_\_  
Signature of Patient or Responsible Party if a Minor

\_\_\_\_\_  
Please Print Name of Patient

\_\_\_\_\_  
Signature of Co-responsible Party

Date \_\_\_\_\_



Patient Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Confidential Health History:

Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Reason's for today's visit: \_\_\_\_\_

Current or past problems with:	Yes	No	Have you had any illnesses, hospitalizations or surgeries? (in the last 5 years)
General Health	___	___	Yes ___ No ___
Eyes	___	___	Are you taking any medications that thin the blood?
Heart	___	___	Yes ___ No ___
Lungs	___	___	Have you been examined by a dermatologist in the past?
Stomach/Bowel	___	___	Yes ___ No ___
Kidneys	___	___	Family History:
Arthritis/Muscles/Joints	___	___	Check the following medical conditions that have occurred in you family (blood relatives):
Headaches/Seizures	___	___	Acne ___ Allergies ___ Arthritis ___ Asthma ___
Psychological Disorder	___	___	Cancer ___ Diabetes ___ Eczema ___ Hayfever ___
Thyroid/Diabetes	___	___	Heart Disease ___ Malignant Melanoma ___
Blood/Bleeding Disorder	___	___	Psoriasis ___ Skin Cancer ___
Allergic/Immunologic	___	___	Comments: _____
Skin-Acne	___	___	_____
-Dry, sensitive skin	___	___	_____
-History of keloids or scars	___	___	_____
-Skin cancer	___	___	_____
-Melanoma	___	___	_____
-Swelling of ankles	___	___	_____
-Hives	___	___	_____
-Abnormal moles	___	___	_____

Females: Are you pregnant? No / Yes

Are you planning to become pregnant? No / Yes

Social History:

Do you live alone? No / Yes

Do you smoke? No / Yes

Occupation: \_\_\_\_\_

Hobbies/leisure activities: \_\_\_\_\_

Do you use sunscreen? No / Yes

Reviewed: \_\_\_\_\_ Date: \_\_\_\_\_ Update: \_\_\_\_\_  
(MD Signature)