Payment is expected on the day services are rendered. We accept cash, checks, Visa, MasterCard, American Express and Discover.

For those patients who are covered by insurance, we will be happy to bill on your behalf, whenever medically applicable. Any co-pays, co-insurance and/or deductibles as specified by your insurance policy will be collected on the day of service.

We verify your insurance benefits prior to your appointment. So, if you have any questions about your coverage, please ask before services are rendered. Verification of insurance is NOT a guarantee of coverage. Medical necessity is up to the determination of your insurance provider. You, the patient, may be responsible for services even if Manhattan Beach Dermatology/Scott Rackett, MD is contracted with your insurance policy.

We collect an estimate at the time of service. If we have over-collected, please notify us and a refund will be issued promptly. You may have an additional balance after your insurance processes our claim. Any outstanding balance that is your responsibility will be expected to be paid in full within 30 days of notification.

To avoid a $50 cancellation fee, please provide at least 24 hours’ notice if you cannot keep your appointment.

Thank you,
Scott Rackett, MD and Staff

I understand that I will be expected to pay for all applicable fees the day of service.

I understand that I am responsible for any balances not covered by my insurance.

I will assume responsibility of notifying this office of any changes to my insurance coverage.

I authorize the release of any medical or other information necessary to process my claim.

I authorize payment of medical benefits to Manhattan Beach Dermatology/Scott C. Rackett MD for medical services.

I understand that I will be charged $50 for any appointments cancelled or missed without 24 hours’ notice.

I have read and agree to this financial policy.

____________________________________  __________________________
Signature of patient/parent or legal guardian of a minor  Date

__________________________
Print Name

__________________________  __________________________
Relationship to Patient  Date
Patient Information

All patients under the age of 18 must be accompanied by a parent or legal guardian. (please print)

Last Name: ________________________________ First Name: __________________________ MI: ______

Address: __________________________________ Apt: _____ City: __________________________ State_____ Zip_____

Date of Birth________ Age_________ Male □ Female □ Driver’s License/ID#:________________ State _____

Home Telephone: (_____) _______________ Cell Phone (_____) ____________ Social Security Number: ___________________________________________ (Protected by HIPPA Privacy Act)

Single □ Married □ Widowed □ Divorced □ Race _______ Ethnicity ________ Preferred Language______________

Employer: ___________________________ F/T □ P/T □ Unemployed □ Work Phone :(____) ___________________________

Occupation: ___________________________ Employer Address: __________________________________________

Email Address: ___________________________ □Yes □NO May we communicate with you via e-mail

How were you referred to this office? □ Insurance □ Friend □ Doctor: ___________________________ (doctor’s name and city)

Primary Physician Name: ____________________________ Phone __________________________ Fax ______________

Preferred pharmacy address and phone number: ___________________________________________________

INSURANCE INFORMATION

Please give your insurance card to the receptionist.

GUARANTOR/INSURED INFORMATION: If you are NOT the policyholder, please provide the following:

Policyholder’s name: ___________________________ Male □ Female □ Date of Birth ________________

Policyholder’s address: ___________________________ Patient’s relationship to policyholder: ____________

Policyholder’s Social Security number: _________________ (Protected by HIPPA Privacy Act)

Employer: ____________________________ Employer address: __________________________________________

EMERGENCY

Name: ___________________________ Relationship to patient: __________________

Home telephone: (_____) ______________ Work telephone: (_____) ____________

Do we have your permission to:

1. Leave messages on your answering machine regarding confidential biopsy/lab results?
   Yes □ No □ If yes, please note preferred phone number: □ Home □ Cell □ Work □ Other (___) ______

2. Discuss your medical condition with any member of your household? Yes □ No □
   If yes, whom: ___________________________ Relationship: ____________________ □ Same as emergency contact

ACKNOWLEDGEMENT OF RECEIPT

I hereby acknowledge that I have received a copy of Manhattan Beach Dermatology’s Notice of Privacy Practices.

Signature ___________________________ ___________________________ Date ______________

Patient signature / Parent or legal guardian of minor Print Name Relationship to patient

ALL THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE

Signature ___________________________ ___________________________ Date ______________

Patient signature / Parent or legal guardian of minor Print Name Relationship to patient
**Personal Medical History**

Name ____________________________________ Date ____________________________

**REASON FOR TODAY'S VISIT**

**PAST MEDICAL HISTORY:** (check all that apply)

- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Atrial Fibrillation (Irregular Heartbeat)
- □ Bone Marrow Transplantation
- □ BPH (Enlarged Prostate)
- □ Breast Cancer
- □ Colon Cancer
- □ Chronic Obstructive Pulmonary Disease
- □ Coronary Artery Disease
- □ Depression
- □ Diabetes
- □ End Stage Renal Disease
- □ GERD (Acid Reflux Disease)
- □ Hearing Loss
- □ Hepatitis (A, B, or C)
- □ High Blood Pressure
- □ HIV / AIDS
- □ High Cholesterol
- □ Over Active Thyroid
- □ Under Active Thyroid
- □ Leukemia
- □ Lung Cancer
- □ Lymphoma
- □ Prostate Cancer
- □ Radiation Treatment
- □ Seizures
- □ Stroke
- □ Other __________________________

**PAST SURGICAL HISTORY**

- □ Heart: Mechanical Valve
- □ Joint Replacement
- □ Other surgeries:
  __________________________________
  __________________________________
  __________________________________

**Please let us know if you are experiencing any of the following:**

- □ Tuberculosis (or symptoms of TB; coughing & fever)
  If yes, are you experiencing any of the following:
  - □ Productive cough
  - □ Night sweats
  - □ Fatigue
  - □ Malaise
  - □ Fever
  - □ unexplained weight loss

**SKIN DISEASE HISTORY:** (Check all that apply)

- □ Acne
- □ Actinic Keratosis (Precancers)
- □ Asthma
- □ Basal Cell Skin Cancer
  Body Location __________________________
- □ Blistering Sunburns
- □ Dry Skin
- □ Eczema
- □ Flaking or Itchy Scalp
- □ Hay Fever / Allergies
- □ Melanoma
  Body Location _________________________
- □ Poison Ivy
- □ Precancerous Moles
  Body Location _________________________
- □ Psoriasis
- □ Squamous cell skin cancer
  Body Location _________________________
- □ Other ______________________________

**Do you wear sunscreen?**

- □ Yes  □ No

  **If yes, what SPF? ________**

**Do you tan in a tanning salon?**

- □ Yes  □ No

**Do you have a family history of Melanoma?**

- □ Yes  □ No

  **If yes, which relative?**

---

2809 North Sepulveda Boulevard, Suite A, Manhattan Beach, CA 90266 • www.mbderm.com • T: 310.802.8180 • F: 310.802.8150
### Personal Medical History

**ALLERGIES:** (Please enter all food, medical allergies and their reactions)

<p>| |</p>
<table>
<thead>
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**MEDICATIONS:** (Please enter all current medications)

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</tbody>
</table>

**SOCIAL HISTORY:** (Check all that apply)

**Drug and Alcohol use**

- [ ] Drug use
- [ ] IV Drug use
- [ ] Alcohol-none
- [ ] Alcohol-less than 1 drink per day
- [ ] Alcohol-1-2 drinks per day
- [ ] Alcohol-3 or more drinks per day

**Smoking Status**

- [ ] Current every day smoker
- [ ] Current some day smoker
- [ ] Former smoker
- [ ] Never smoked

**Occupation and Workplace**

- [ ] Indoors
- [ ] Outdoors

**FAMILY HISTORY:** (Is there a history in your family of the following diseases?) Below the condition write down who in your family had the condition. (Mother, Father, Sister etc.)

<table>
<thead>
<tr>
<th>Disease</th>
<th>Family Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne</td>
<td></td>
</tr>
<tr>
<td>Allergies / Hay Fever</td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
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<tr>
<td>Eczema</td>
<td></td>
</tr>
<tr>
<td>Heart disease</td>
<td></td>
</tr>
<tr>
<td>Lung disease</td>
<td></td>
</tr>
<tr>
<td>Psoriasis</td>
<td></td>
</tr>
<tr>
<td>Abnormal Moles</td>
<td></td>
</tr>
<tr>
<td>Malignant melanoma</td>
<td></td>
</tr>
<tr>
<td>Basal cell skin cancer</td>
<td></td>
</tr>
<tr>
<td>Squamous cell skin cancer</td>
<td></td>
</tr>
<tr>
<td>Actinic keratosis (precancers)</td>
<td></td>
</tr>
<tr>
<td>Other Cancer(s)</td>
<td></td>
</tr>
<tr>
<td>Other condition(s)</td>
<td></td>
</tr>
</tbody>
</table>
# REVIEW OF SYSTEMS: (CHECK ALL THAT CURRENTLY APPLY)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Immunosuppression</td>
<td>☐ Pacemaker</td>
</tr>
<tr>
<td>☐ Changing mole</td>
<td>☐ Defibrillator</td>
</tr>
<tr>
<td>☐ Rash</td>
<td>☐ Artificial joints within past two years</td>
</tr>
<tr>
<td>☐ Abdominal pain</td>
<td>☐ Artificial heart valve</td>
</tr>
<tr>
<td>☐ Anxiety</td>
<td>☐ Do you need medication prior to procedures</td>
</tr>
<tr>
<td>☐ Bloody Stool</td>
<td>☐ Allergy to adhesive</td>
</tr>
<tr>
<td>☐ Bloody Urine</td>
<td>☐ Allergy to topical antibiotic ointments</td>
</tr>
<tr>
<td>☐ Blurry Vision</td>
<td>☐ Blood thinners</td>
</tr>
<tr>
<td>☐ Chest Pain</td>
<td>☐ Allergy to lidocaine</td>
</tr>
<tr>
<td>☐ Cough</td>
<td>☐ Rapid heartbeat with epinephrine</td>
</tr>
<tr>
<td>☐ Depression</td>
<td>☐ Yeast infections with antibiotics</td>
</tr>
<tr>
<td>☐ Fever or Chills</td>
<td>☐ GI upset with antibiotics</td>
</tr>
<tr>
<td>☐ Headaches</td>
<td>☐ Problems with bleeding</td>
</tr>
<tr>
<td>☐ Hay Fever</td>
<td>☐ Problems with healing</td>
</tr>
<tr>
<td>☐ Light headedness, dizziness</td>
<td>☐ Problems with scarring (hypertrophic or keloid)</td>
</tr>
<tr>
<td>☐ Joint Aches</td>
<td>☐ Allergy to latex</td>
</tr>
<tr>
<td>☐ Muscle Weakness</td>
<td>☐ Nursing currently</td>
</tr>
<tr>
<td>☐ Neck Stiffness</td>
<td>☐ Pregnant currently or Planning a pregnancy</td>
</tr>
<tr>
<td>☐ Night Sweats</td>
<td>☐ Lightheaded / pass out during procedures</td>
</tr>
<tr>
<td>☐ Shortness of Breath</td>
<td></td>
</tr>
<tr>
<td>☐ Sore Throat</td>
<td>Birth Control Method:</td>
</tr>
<tr>
<td>☐ Thyroid Problems</td>
<td>Number of Children:</td>
</tr>
<tr>
<td>☐ Unintentional Weight Loss</td>
<td>Children Ages:</td>
</tr>
<tr>
<td>☐ Wheezing</td>
<td></td>
</tr>
</tbody>
</table>

---

Patient signature / Parent or legal guardian of minor  Print Name  Relationship to patient  Date
With respect to facial aesthetics, please mark those areas of the face that bother or trouble you. In the boxes provided please rate these areas on a scale of 1 to 5 (1 being least bothersome, 5 being most bothersome). Feel free to draw in the chart to identify any other facial concerns.