

PATIENT INFORMATION (Please print)

Last Name: _____ First Name: _____ MI: _____

Address: _____ Apt: _____ City: _____ State _____ Zip _____

Date of Birth _____ Age _____ Male Female Race _____ Ethnicity _____

Home Telephone: (____) _____ Cell Phone (____) _____ Social Security Number : _____

(Protected by HIPPA Privacy Act)

Single Married Widowed Divorced Drivers License/ID#: _____ State _____

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

Occupation: _____ Employer Address: _____

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

(We will never share your email address with anyone)

How were you referred to this office? _____ Preferred Language _____

Have you ever seen another physician for this problem? Yes No If yes, name: _____

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 **X** _____ Date _____

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

All the above information is true to the best of my knowledge.

Signature **X** _____ Date _____

Patient signature / Parent or legal guardian of minor

Personal Medical History

Name _____ Reason for today's Visit _____

Medication Allergies: _____
Type of reaction _____

NON-MEDICATION ALLERGIES: Latex _____ Others (food, tape, etc) _____

DO YOU REGULARLY TAKE ASPIRIN? _ Yes _ No Height _____ Weight _____ lbs

CURRENT MEDICATIONS: _____

MEDICAL HISTORY: (check all that apply)

| | | | |
|---|--|---|---|
| <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Artificial Joint <input type="checkbox"/> Artificial heart valve <input type="checkbox"/> Asthma <input type="checkbox"/> Abnormal moles <input type="checkbox"/> Bleeding, excessive <input type="checkbox"/> Cancer type _____ <input type="checkbox"/> Skin cancer <input type="checkbox"/> Basal Cell Carcinoma Site _____ <input type="checkbox"/> Squamous cell carcinoma Site _____ | <input type="checkbox"/> Cataracts <input type="checkbox"/> Cholesterol <input type="checkbox"/> Colon/intestinal disorder <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Eczema <input type="checkbox"/> Epilepsy / Seizures <input type="checkbox"/> Glaucoma <input type="checkbox"/> Hair loss <input type="checkbox"/> Liver disease <input type="checkbox"/> Hay Fever / Allergies <input type="checkbox"/> Heart problems / Murmur | <input type="checkbox"/> Hepatitis (A,B, or C) <input type="checkbox"/> Herpes simplex (cold sores) <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> HIV disease (AIDS) <input type="checkbox"/> Hives <input type="checkbox"/> Kidney Disease / Stones <input type="checkbox"/> Lung disease <input type="checkbox"/> Malignant melanoma <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Pacemaker <input type="checkbox"/> Psoriasis <input type="checkbox"/> Scarring / Keloids <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Tuberculosis (or symptoms of TB; coughing & fever) If yes, are you experiencing any of the following: <input type="checkbox"/> productive cough <input type="checkbox"/> Night sweats <input type="checkbox"/> Fatigue <input type="checkbox"/> Malaise <input type="checkbox"/> Fever <input type="checkbox"/> unexplained weight loss <input type="checkbox"/> Ulcers <input type="checkbox"/> Warts <input type="checkbox"/> Genital Warts |
|---|--|---|---|

Other Condition(s) describe _____

Women Only: Birth control method _____ _ Currently pregnant _____ wks
 _ Actively trying to conceive Number of Children and ages _____

HOSPITALIZATION/SURGICAL HISTORY: (past 2 years) _____

SOCIAL HISTORY: Do you smoke/chew tobacco? _ Yes _ No Drink alcohol _ never _ socially _ daily

FAMILY HISTORY: Is there a history in your family of the following diseases?

Acne Eczema Malignant Melanoma Tuberculosis
 Allergies / hayfever Heart disease Psoriasis
 Asthma Lung disease Skin cancer Types _____

Other condition(s) _____

Signature of patient _____ Date _____



Manhattan Beach Dermatology

2809 N. Sepulveda Blvd.,
Manhattan Beach, CA 90266
Phone: 310.802.8180 - FAX: 310.802.8150

MANHATTAN BEACH DERMATOLOGY FINANCIAL POLICY

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.

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 have read and agree to this financial policy.

Date _____

Signature of patient/parent or legal guardian of a minor



MEDICAL CORPORATION

Manhattan Beach Dermatology

2809 N. Sepulveda Blvd.
Manhattan Beach, CA 90266
Phone: 310.802.8180 - FAX: 310.802.8150

Cosmetic Interest Questionnaire (Optional)

For many people, changes in physical appearance as we age can have a significant impact on self-confidence and even quality of life. Fortunately, today there are many options available to enhance one's appearance and reverse the signs of aging.

Please let us know which of the following might interest you.

- Dermal fillers such as Restylane, Collagen, Juvederm, Radiesse and Sculptra _____

- Anti wrinkle creams _____

- Botox or Dysport _____

- Laser treatments for wrinkles _____

- Laser treatments for rosacea/facial redness/ facial veins _____

- Leg vein treatment _____

- Treatment for brown spots/age spots _____

- Light skin peels _____

- Acne facials/extractions _____

- Hair removal _____

- Topical medication to promote thicker and longer eye lashes _____

- Microdermabrasion _____

- Rejuvenating Facials _____

Have you had any of the above treatments in the past? _____

Do you need sunscreen suggestions or advice _____
What skin care products are you currently using? _____

NAME _____ PHONE _____ DATE _____