KALIA | DERMATOLOGY & LASER CENTER

Patient Registration Form

Last Name: ____**First Name:** ____________________________________

Address: _______________________________________ **City:** _________________________ **ZipCode:** _________

Date of Birth: _____ / ______ / ________ **Sex:** Female / Male (circle one)

Home Phone: _______-________-__________ *****Cell Phone:** _______-________-__________

*****PREFFERED phone number: Cell:**_______ **Home:**________ (check one)\
Employer Name: _________________________________ **Marital Status:** ______________________________________

Occupation: ____

*****Does our office have permission to leave a detailed message? Yes:**______ **No:**_______ (check one)

Primary Care Physician: ____

*****Email Address:**

How did you hear about us? (choose one) **Patient or Doctor Referral**: ____
___Yelp ___ Google Search ___ NBC ___ San Jose Mercury News ___ Yellow Pages
___ Insurance Network Directory ___ Facebook ___ other: _________________________

*****EMERGENCY CONTACT:**
Last Name: ____ **First Name:** ___________________________________
Contact's Phone: _______-_______-__________ **Relationship to patient:** ____

Primary Insurance: Please enter name exactly as it appears on the insurance card:
Insurance Company: ____
*****Policyholder's name (Required):** ____
*****Policyholder's date of birth:** _________/_________/__________

Relationship to Patient: (circle one) self spouse parent other________________________________

PATIENT SIGNATURE: ____ **Date:** ________________________

Parent Signature ***if patient is under 18 years of age*****:** ____

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History and Intake Form

First Name:____________________________**Last Name:**__________________________________**Date:**_____________

Reason(s) for today's visit:____

PHARMACY: Name / Location: ______________________________________**Phone:** ________-________-___________

Medical History: (Please check all that apply or check NONE)

- ❑ NONE
- ❑ Accutane/anticoagulants within the last 6 months.
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial fibrillation
- ❑ Bone Marrow Transplantation
- ❑ BPH
- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ COPD
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes
- ❑ End Stage Renal Disease
- ❑ GERD
- ❑ Hearing Loss
- ❑ Hepatitis
- ❑ Hypertension
- ❑ HIV/AIDS
- ❑ High Cholesterol
- ❑ Hyperthyroid
- ❑ Hypothyroid
- ❑ Leukemia
- ❑ Lung Cancer
- ❑ Lymphoma
- ❑ Prostate Cancer
- ❑ Radiation Treatment
- ❑ Seizures
- ❑ Stroke
- ❑ Pacemaker
- ❑ Use of Minocyclines, Tetracycline, Vitamin E, or St. John's Wort, all which have been known to induce photo sensitivity to light exposure at the wavelengths used with IR (InfraRed)
- ❑ Other ____

____

*****Have you had your flu shot this year? Yes:______ No:_______** (check one)

Past Surgical History: (Please check all that apply or check NONE)

- ❑ NONE
- ❑ Appendix Removed
- ❑ Bladder Removed
- ❑ Breast Biopsy (Right, Left)
- ❑ Breast: Lumpectomy (Right, Left)
- ❑ Breast: Mastectomy (Right, Left)
- ❑ Colectomy: Colon Cancer Resection
- ❑ Colectomy: Diverticulitis
- ❑ Colectomy: Inflammatory Bowel Disease
- ❑ Colon: Colostomy
- ❑ Gallbladder Removed
- ❑ Biological Valve Replacement
- ❑ Coronary Artery Bypass Surgery
- ❑ Heart Transplant
- ❑ Mechanical Valve Replacement
- ❑ Heart: PTCA
- ❑ Joint Replacement - Knee (Right, Left)
- ❑ Joint Replacement - Hip (Right, Left)
- ❑ Joint Replacement within last 2 years
- ❑ Kidney Biopsy (Nephrectomy)
- ❑ Kidney Removed (Right, Left)
- ❑ Kidney Stone Removal
- ❑ Kidney Transplant
- ❑ Liver: Hepatectomy
- ❑ Liver: Liver Transplant
- ❑ Liver: Shunt
- ❑ Ovaries Removed: Endometriosis
- ❑ Ovaries Removed: Cyst
- ❑ Ovaries Removed: Ovarian Cancer
- ❑ Pancreas Removed
- ❑ Prostate Cancer
- ❑ Prostate Biopsy
- ❑ TURP (Prostate Removal)
- ❑ Rectum APR
- ❑ Rectum Low Anterior Resection
- ❑ Spleen Removed
- ❑ Superficial metal or other implants
- ❑ Testicles Removed (Right, Left)
- ❑ Hysterectomy: Fibroids
- ❑ Hysterectomy: Uterine Cancer
- ❑ Hysterectomy: Cervical Cancer
- ❑ Recent Permanent Makeup / tattoos, location:____

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Other ____

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Skin Disease History: (Please check all that apply or check NONE)

- ❑ NONE
- ❑ Acne
- ❑ Actinic Keratoses
- ❑ Basal Cell Skin Cancer
- ❑ Blistering Sunburns
- ❑ Dry Skin
- ❑ Eczema
- ❑ Flaking or Itchy Scalp
- ❑ Hay Fever/Allergies
- ❑ Herpes Labialis / Cold Sores
- ❑ Herpes Simplex or Shingles
- ❑ Keloids
- ❑ Melanoma
- ❑ Poison Ivy
- ❑ Atypical Moles
- ❑ Psoriasis
- ❑ Squamous Cell Skin
- ❑ Cancer
- ❑ Other ______________________________

Do you wear Sunscreen? (Please circle one) Yes No

If yes, what SPF? ______________________________

Do you tan in a tanning salon? (Please circle one) Yes No

Do you have a family history of Melanoma? (Please circle one) Yes No

If yes, which relative? ______________________________

Medications: (Please enter all current medications) NONE

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Allergies: (Please enter all allergies) NONE

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Social History: (Federal guidelines require us to ask these questions. Answering is optional)

Cigarette Smoking: (Please check one)

- ❑ Smokes Less Than Daily
- ❑ Smokes Daily
- ❑ Never Smoked
- ❑ Quit: Former Smoker

Alcohol Intake: (Please check one)

- ❑ None
- ❑ Less than 1 drink per day
- ❑ 1-2 drinks per day
- ❑ 3 or more drinks per day

65 Years or Older:

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women?

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For Women: (Please circle all that apply)

Pregnant - Yes/No Nursing - Yes/No Hormone Replacement Therapy – Yes/No

Medical Conditions That Run In The Family: (Including skin cancer)

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FINANCIAL POLICY

Insurance plans in which we are a participating provider
For covered services, we ask that all co-pays and deductibles be paid at the time of service. For some insurance plans, the amount of the co-payment varies depending on the services(s) performed, and we reserve the right to modify the billing if the correct payment due was not known at the time of service. If you state that you have valid insurance coverage at the time of your service, but it is later determined that you were not covered, you acknowledge that you are responsible for the entire fee.

Insurance plans in which we are NOT a participating provider
We may be able to courtesy bill your PPO plan first, and then bill you for the balance that was not paid by your insurance. Please ask us about this option. Unfortunately, we are unable to bill any HMO's. In this case, we ask that you pay the entire fee at the time of service. We would be happy to give you an estimate of the services you are requesting before they are performed.

Some services are considered "not medically necessary" and are not covered by your insurance plan. Unfortunately, we don't always know what each individual plan covers, as their policies are constantly changing. If we bill your plan for services rendered, and your plan determines that the services were not covered because they were "not medically necessary," you will be responsible for the entire fee. All esthetician services, chemical peels, facials, blue light treatments, light and laser services, sclerotherapy, Botox, and fillers are not billable to insurance.

Payment and Insurance Agreement/ Release Authorization and Assignment of Benefits
I attest that the above information is correct and will be used for billing purposes. I authorize the release of medical information to my insurance company(s), primary care or referring physicians and pharmacies. Further, my signature authorizes Kalia Dermatology and Laser Center, Inc. to release medical information necessary to process my insurance claims. I understand that I am responsible for my bill. I authorize Kalia Dermatology and Laser Center, Inc. to act as my agent in helping me obtain payment from my insurance company(s). I also authorize payment directly to Dr. Iris Gin and Kalia Dermatology and Laser Center, Inc., of the group insurance benefits otherwise payable to me. A copy of this may be used in place of the original.

For Our Medicare Patients: Medicare Authorization to Pay Benefits to Physician
I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by Dr. Iris Gin. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.
I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the HCFA 1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient Signature: ____ **Date:** _____________

Patient Name (please print)**:** ____

If not signed by the patient, please indicate relationship:

- □ Parent or guardian of minor patient
- □ Guardian or conservator of an incompetent patient
- □ Beneficiary or personal representative of deceased patient
- □ Name of patient: _________________________________