PATIENT DATA SHEET

Name:____

Address: ____________________ City: ________________State: _____ Zip: ________

Cell Phone: _______________ Home Phone: _________________ Work: _____________

Date of birth: __________________ Social Security:_____________________________

May our office leave a message on your voice mail? Yes No

If unable to reach you, who else can we call: ____________________________________

By providing your email address here ______________________________, you authorize us to email you information such as appointment reminder, e-statements, specials. We will respect your privacy.

Employer Name: ___________________ Employer Address: ______________________

Family Physician Name and Address: ____

Emergency Contact Person: ____

Pharmacy of Choice: ________________________________ City: __________________

Signature: ______________________________ Date:_____________________________

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. In the event that your account must be turned over to collections, a $35.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Signature: ______________________________ Date:_____________________________

PATIENT FINANCIAL POLICY & SIGNATURE ON FILE

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

Signature: _______________________________________ Date: ____________

PAYMENT POLICY:
MEDICARE PATIENTS: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% co-payment, We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be billed for the balance.
NOTE: If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers.

MEDICARE PATIENTS ONLY:
This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:
I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or related Medicare Claim. I permit copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment, Regulations pertaining to Medicare assignment of benefits apply.

Signature: _______________________________________ Date: ____________

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file.
I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me, I authorize any holder of my information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature: _______________________________________ Date: ____________

PRIVATE INSURANCE PATIENTS:
You will be responsible for paying your annual deductible, co-payment and charges for any non-covered cosmetic services.
NOTE: Patients who are covered by private, commercial plans in which our physicians are NOT providers will be required to pay 50% of total bill at the time of service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

*Dr Oriba does not accept Medi-Cal or Central Coast Alliance. Check with your carrier if you have questions

Signature: ______________________________________ Date: ____________

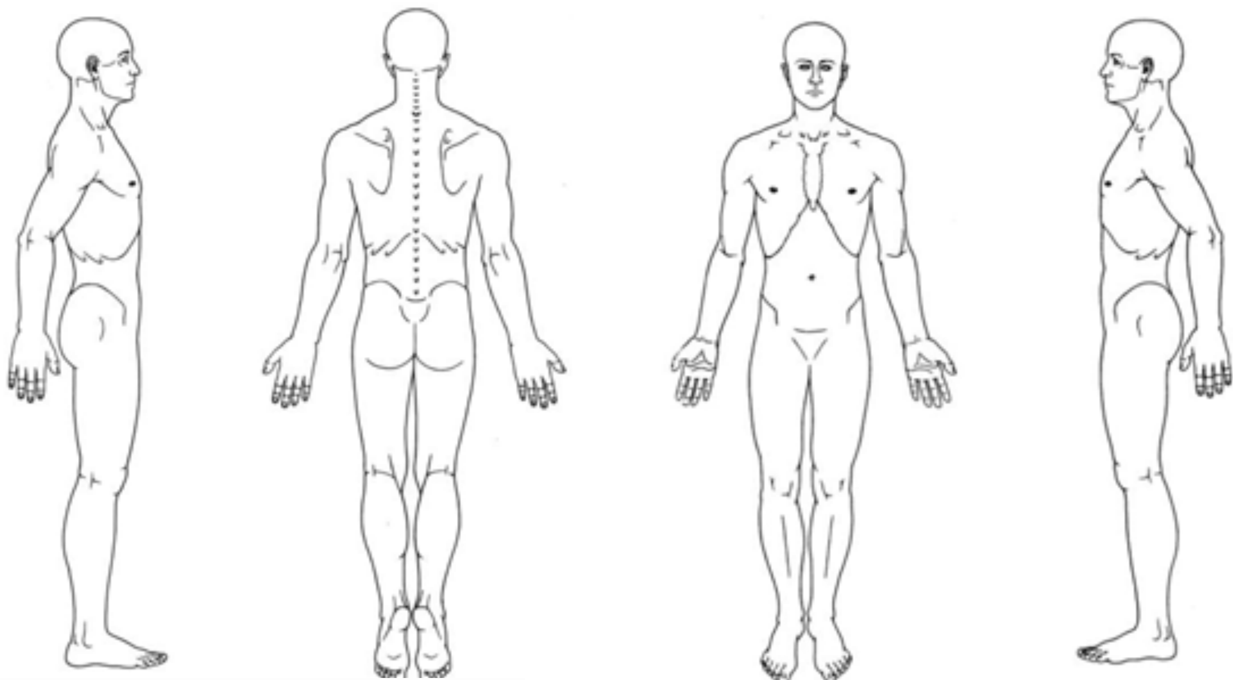
CURRENT PROBLEM QUESTIONNAIRE

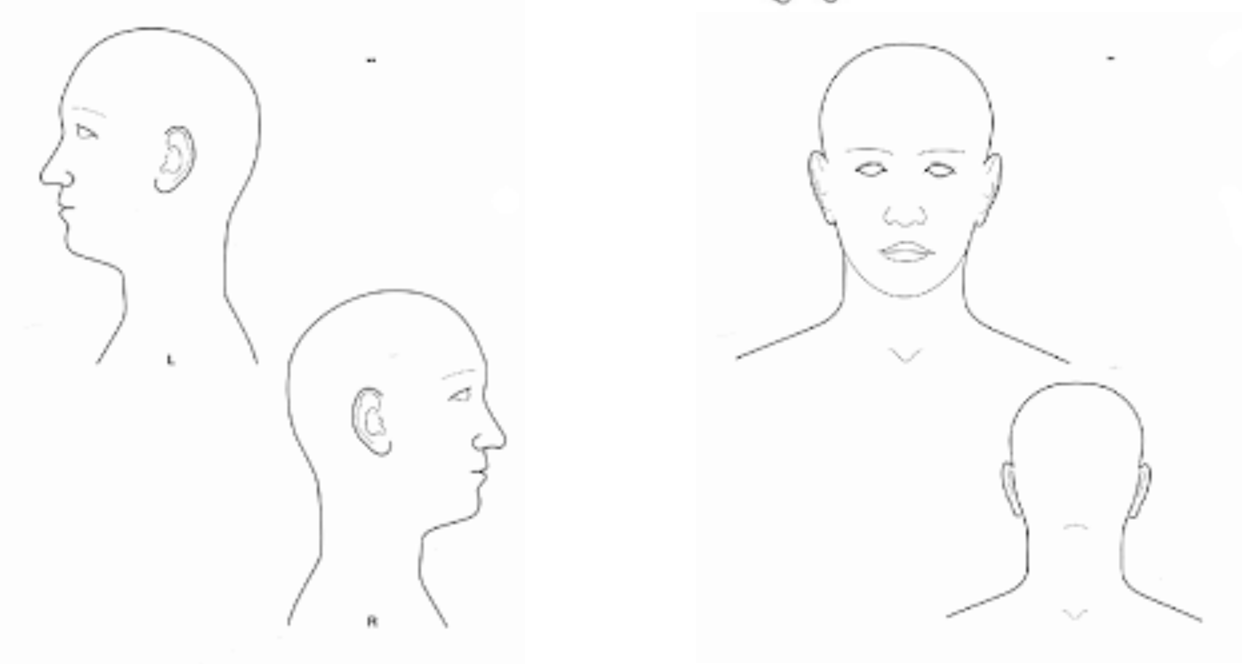
NAME: ___________________________ DATE: ________________________________

Skin problem being seen for today (rash, growths, warts, etc.): ____________________
____

Duration of the skin problem (when first noticed):________________________________

Please mark on the figure where your present skin problem is located.





PLEASE CIRCLE "YES" OR "NO: FOR THE FOLLOWING QUESTIONS:

1. Have you had any other skin problems? If so, please list: yes no
____

2. Does anyone in your family have repeated skin problems or rashes? yes no

3. Has a doctor given you anything for the current skin problem? If yes, yes no
please list the names of everything used: _____________________________
____

4. Have you applied anything to your skin for the problem? If yes, please yes no
give the names of everything used. __________________________________
____

5. Does anything touching your skin cause a rash or allergy? (jewelry, yes no
poison oak, poison ivy, etc.) If yes, please list. _________________________
____

6. Are you allergic to any medications? {penicillin, aspirin, etc.) If yes, please
list:____ yes no

7. Please list all medications you are currently taking: _____________________________
____

8. Are you pregnant? yes no

Signature: ___________________________ Date: ________________________

Dermatology Medical History

Name: ____ Date of Birth: ____/____/____

Are you **allergic** to any medications? YES NO If yes, what are they:______________________________________

____

Have you ever had dental anesthesia (Novocaine)? YES NO Any **bad** reaction? YES NO

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals):

____

____

List **surgical procedures** you have had in the last 6 months: ______________________________________

____

Skin: Have you ever had skin cancer? YES NO
Has anyone in your family had skin cancer? YES NO
Do you have a history of any specific skin diseases? YES NO If yes, ____________________________________

____

Do you have problems with healing YES NO
Do you develop keloids (scars) after surgery YES NO
Do you bleed easily? YES NO
Do you develop skin rashes in reaction to Medications Food Environment Bandages Topical Neosporin
Other;____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)
List any other diseases or conditions, if you feel it is important to know:

Lungs:

Bronchitis	YES	NO
Emphysema	YES	NO
Asthma	YES	NO
Chronic Cough	YES	NO
Shortness of Breath	YES	NO
Wheezing	YES	NO
Tuberculosis	YES	NO
Cardiovascular:		
Pacemaker	YES	NO
High Blood Pressure	YES	NO
Chest Pain	YES	NO
Heart Attack	YES	NO
Heart Murmur	YES	NO
Irregular Heartbeat	YES	NO
Phlebitis	YES	NO
Blood clots	YES	NO
	YES	NO

Other Systemic:

Diabetes	YES	NO
Amputation	YES	NO
Thyroid	YES	NO
Bladder	YES	NO
Kidney	YES	NO
Dialysis	YES	NO
Stomach ulcer	YES	NO
Diarrhea	YES	NO
Arthritis/Joint Deformity	YES	NO
Artificial joint(s)	YES	NO
Seizures	YES	NO
Fainting	YES	NO
Organ Transplantation	YES	NO
Nausea, vomiting, diarrhea when taking antibiotics	YES	NO

Other: ______________________________________

Social History:
Do you drink alcohol? YES NO If YES _________ drinks per day
Do you use IV drugs? YES NO If YES, what? ______________________ How often? ____________________
Do you smoke? YES NO, how much: ____
Have you had or have you been exposed to HIV (AIDS) ? YES NO

(Women) Are you pregnant**?** YES NO Due Date: ___/___/___
What is/was your occupation? ____________________________ Are you retired? YES NO

Who referred you to us: Doctor Colleague Ad Insurance Internet Yellow pages

_____________________________________ ________________
Signed by patient Date