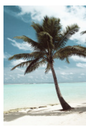

Dr. Leila Ettefagh

Island Dermatology
360 San Miguel Dr., St. 501
Newport Beach, CA 92660
(949) 720-1170

Dr. Navid Nami

Patient Information

Name ____ Driver's Lic. # __________________
Last First Initial

Address __________________________________ City_________________ State_____ Zip_________

Home Phone ___________________ Cell Phone_________________ Work Phone _________________________

Best Phone Number to call for appointment reminders and results: Home / Cell / Work

Sex: M_____ F _____ Birth date _______________ Maiden Name______________________________

Patient Employed By________________________ Business Address ____________________________________

Name of Spouse _____________________________ Spouse Cell Phone _________________________________

In case of emergency, who should be notified? ________________________ Phone ________________________

If visiting from out of town, please provide a local phone number ______________________________________

Referred by: Doctor____________________________Friend/Relative__________________ Other _____________

Would you like to receive Island Dermatology Newsletters via email ______YES ______ NO
Email Address: ____

Primary Insurance

Subscriber Name ____
Last First Initial
Subscriber Birth date_______________ SSN #_____________________ Relation to Patient__________________

Secondary Insurance

Is Patient covered by additional insurance? Yes_____ No_____

Subscriber Name ____
Last First Initial
Subscriber Birth date _______________ SSN #_____________________ Relation to Patient_________________

Acknowledgement of Receipt of Notice of Privacy Practices

Island Dermatology reserves the right to modify the privacy practices outlined in this notice.

I have reviewed or received a copy of the Notice of Privacy.

____
Name of Patient (please print)

____ ________________ __________
Signature of Patient/If Patient is a Minor /signature of Patient Representative **Relationship to patient** **Date**

Please note that State and Federal Law provides additional protections for minors and restricts the release of certain patient information to anyone other than the minor patient.

Name of Person Completing this form ___________________________________ Date_________________

A signed Financial Agreement is also required prior to treatment

 Staff Int.____________

Island Dermatology

Medical History Form

Patient Name____ **Date**_______________________

Reason for today's visit: ____

Who can we thank for referring you to our office: ____

Allergies to Medications: ____ None _________________

Current Medications: ____ None _________________

SKIN CANCERS (Please Circle)

History of Skin Cancer? **NONE** Melanoma Squamous Cell Basal Cell

Family history of Skin Cancer? **Yes / No** Family history of Melanoma? **Yes / No**

SYMPTOMS Are you having any symptoms today? (Please Circle)

Headache	Diarrhea	Abdominal Pain
Nausea/Vomiting	Cough	Dizziness
Shortness of Breath	Chest Pain	Fever / Chills
Irregular Heartbeat	Vision Loss	**NONE OF THE ABOVE**

PAST MEDICAL HISTORY (Please Cirlce)

High Blood Pressure	Diabetes	Heart Disease	HIV/Hepatitis B/C
Artificial Heart Valves	Artificial Joints	Blood Clots	Brain Stunt
Glaucoma	Kidney Disease	Emphysema	Thyroid Disease
Pacemaker	Automated Defibrillator	Mitral Valve Prolapse	**NONE OF THE ABOVE**

PAST SURGERIES:

Y	N	
__	__	Do you pass-out easily with medical procedures
__	__	Do you scar / keloid easily
__	__	Do you require antibiotics prior to surgery
__	__	Do you drink alcohol If yes: _____Occasional ____Daily
__	__	Do you smoke If yes: _____ packs per day
__	__	Do you use or have ever used intravenous drugs
__	__	Do you have any **Latex** allergies
__	__	Have you ever had any adverse reaction to Dental Anesthesia
__	__	Are you Pregnant

Occupation___________________

Preferred Pharmacy/Location____

Patient Signature______________________________ Physician Signature______________________________

ISLAND DERMATOLOGY

PRACTICE/PATIENT FINANCIAL AGREEMENT

Patient Name: ________________________________ Date: _______________
(Please print)

We are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask you adhere to the following guidelines:

1. Proof of Insurance and Photo ID are required for <u>all</u> patients.

2. It is your responsibility to provide us with your current address, telephone number and insurance information at each visit.

3. **It is your responsibility to contact your insurance carrier to confirm that our physicians participate in your plan as well as to know your benefit levels (Deductibles, co pays). If you see a doctor that is not currently on your plan, you will be responsible for payment in full. Please be advised it <u>Your</u> responsibility to request what charges will be sent to insurance <u>Prior</u> to services performed. At that time a quote will be provided for what will be billed to insurance we are <u>Unable</u> to to advise of your final patient responsibility until claim has been processed by your insurance,**

4. **WE DO NOT ACCEPT CHECKS FOR COPAYMENTS OR SELF PAY/COSMETIC PROCEDURES.**

5. In order to schedule a surgical procedure we will collect in advance any **unmet** deductibles/co-insurance that is set forth by your insurance.
   - **Payment in full on any patient balance is expected at check-in.**
   - **$10.00 service fee will be charged for failure to pay copayment at time of service.**

6. If you miss your appointment or do not cancel within **24 business hours** you will be charged a **$50.00** fee that will be due **prior** to rescheduling a new appointment.

7. All medical record requests must be in writing and received in our office 72 hours prior to the date needed.

8. The adult accompanying a minor and the parents (or guardians) are responsible for full payment.

9. For unaccompanied minors, non-emergency treatment will be denied unless consent for treatment is on file and payment arrangements have been made and verified to be on file in advance.

10. Please be aware that for biopsy specimens it may be necessary to utilize an <u>“Outside Laboratory”</u>. You will receive a <u>separate</u> bill from them in <u>addition</u> to a bill from us for services rendered. Patient to advise our office of their Lab preferences **prior** to procedures; we will do our best to accommodate lab choice.

I have read and understand the Financial Policy set forth by Island Dermatology.

If Minor, Responsible Party’s Name______________________ Relationship______________

Patient Signature ____________________________________ Date_____________________