Antoanella Calame, MD Nadine Ruth, MD Naomi Travers, NP Nathan Uebelhoer, DO

POWAY DERMATOLOGY
Medical. Aesthetic. Surgical.

Date: / /
M D Y

Name: _____ Age: _____ DOB: ___/___/___
Last First Middle M D Y

Address: _____
Number/Street City State Zip

Phone: _____ Email: _____

May we leave a message on your phone regarding lab and biopsy results? Yes I No

Soc. Sec. #: _____-_____-_____ Sex: M I F Ethnicity (please circle): Non-Hispanic I Hispanic

Race: ○ Caucasian ○ African or African American ○ Asian or Asian American ○ Middle Eastern
○ Native American ○ Native Hawaiian ○ Pacific Islander ○ Other Race

Marital Status: S I M I W Occupation: _____ Insurance: _____

Preferred Pharmacy/Pharmacy Location: _____

Emergency Contact: Name: _____ Relationship to patient: _____

Address (if different): _____ Phone (if different): _____

What is the reason for your visit today? _____

What are you currently using on your skin (liquids, creams, oils, sunscreens)? _____

_____

Please list all current medications and dosages (Prescriptions, Over the Counter Medications, Herbs, Vitamins, Supplements): _____

_____

Thank you for taking the time to complete this form. It will allow us to serve you better.

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Please list all known allergies (please include type of reaction):

_____

_____

Do you have a personal (P) or family (F) history of: (circle all that apply)

P I F - Asthma P I F - Diabetes P I F - High Blood Pressure P I F - Psoriasis
P I F - Basal Cell Cancer P I F - Eczema P I F - Melanoma P I F - Squamous Cell Cancer
P I F - Bleeding Disorder P I F - Heart Disease P I F - Multiple Sclerosis
P I F - Other: _____

Are there any other medical or surgical conditions that affect your day to day health? _____

_____

Do you smoke? Yes I No Quantity: _____ Have you previously smoked? Yes I No

Current Facial Cleanser: _____ Current Sunscreen: _____

Referring Doctor's Name: _____

(Optional) How did you hear about us?

- ○ Family Member / Friend: _____
- ○ Doctor Referral: _____
- ○ Facebook
- ○ Google
- ○ News Station
- ○ Powaydermatology.com
- ○ Patient Fusion
- ○ Special Event
- ○ Yelp
- ○ Insurance Carrier Website (Provider Directory): _____
- ○ Other: _____

(Optional) Do you have any cosmetic concerns such as?

- ○ Acne scars
- ○ Brown spots
- ○ Crow's feet
- ○ Eyelash thinning
- ○ Eyebrow drooping
- ○ Forehead lines
- ○ Frown lines
- ○ Jawline changes
- ○ Jowls / marionette lines
- ○ Lip appearance
- ○ Skin resurfacing / scar treatment
- ○ Skin tags
- ○ Smile / laugh lines
- ○ Smoker's / lip lines
- ○ Sunken eyes
- ○ Sunspots
- ○ Under eye circles
- ○ Uneven skin color texture
- ○ Varicose veins
- ○ Wrinkles

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Patient Service

Agreement

IMPORTANT: PLEASE INFORM US IN THE FUTURE IF YOUR INFORMATION CHANGES

Patient Name _____

BILLING INFORMATION:
In order to control our costs of billing, we request that charges be paid at the time services are rendered unless we will be billing your insurance. To encourage this, a discount of 10% will be given for cash or check and 5% for credit card payment at the time of service. Charges for cosmetic procedures do not receive a discount and must be paid at the time of the visit.
Insurance Information: if you desire that we bill your insurance, please present your insurance card(s) at the front desk. In addition, please provide the following information to expedite processing your claim:

Insured (the person listed on the policy): _____

Patient's Relationship to the Insured: _____

Insured's Date of Birth: _____/_____/_____
M D Y

Please read and sign below:

I authorize the release of the information in my medical records as necessary for my treatment, payment, and healthcare options. I authorize payment of medical insurance benefits to POWAY DERMATOLOGY, a division of Compass Dermatopathology, Inc. and understand that regardless of my insurance coverage, I am financially responsible for all medical services received. I have received a copy of POWAY DERMATOLOGY'S Notice of Privacy Policy Practices.

_____

Signature of Patient or Guardian **Date**

Thank you for taking the time to complete this form. It will allow us to serve you better.

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PATIENT ELECTRONIC MESSAGING CONSENT FORM

By signing this form, I authorize Poway Dermatology to send text message appointment reminders to me on my provided cell phone number. I understand that text messaging rates may/will apply to any messages received from Poway Dermatology that I am responsible for. I also understand that I or Poway Dermatology may revoke this permission in writing at any time. I agree not to hold Poway Dermatology liable for any electronic messaging charges or fees generated by this service. I further agree that in the event my contact/cell phone number changes that I will inform Poway Dermatology or be liable for any fees or charges incurred.

Name: _____ DOB: _____
Print Patient Name

Cell phone # (_____)

My signature below indicates that I represent and warrant that I am the person legally responsible for this account, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services. I understand that this authorization can only be revoked in writing.

_____ _____
Patient Signature Date

It is important to note that text communication is not always secure. Text messages can be intercepted and for this reason, we do not communicate personal health information through this method. Complete terms and conditions can be found at www.greatexpressions.com/text/policy or a copy requested from office staff.

Thank you for taking the time to complete this form. It will allow us to serve you better.