POWAY DERMATOLOGY

A division of Compass Dermatopathology, Inc.
15725 Pomerado Road, Suite 102
Poway, California 92064
(858) 397-5755

MD Notes:

Date : _____ **Account # : _____**

Name: _____ Age:_____ Birthdate:_____/_____/_____
Last First Middle Mo. Day Year

Address: _____
Number/Street City State Zip

(NOTE: Please circle your preferred number at which we may leave messages regarding appointments, results, a medical condition, etc.)

Phone: (H) _____ (W) _____ (Cell) _____

Email : _____ Preferred Language: _____ Ethnicity: ☐ **Non-Hispanic** ☐ **Hispanic**

Race: ☐ **African/African American** ☐ **Asian/ Asian American** ☐ **Caucasian/ European American**
☐ **Native American/Native Alaskan** ☐ **Native Hawaiian/ Other Pacific Islander** ☐ **Other Race**

Soc. Sec. #: _____-_____-_____ Sex: M / F Occupation:_____

Marital Status: _____ Referred By: _____

Emergency Contact: Name: _____ Relationship to patient:_____

Address (if different): _____

Phone (if different): (H) _____ (W) _____ (Cell) _____

Medical History: Please list all current medication dosage in MILLIGRAMS (including Rx, OTC's, herbs, BCP's):

_____

_____

_____

Do you smoke? Y / N Previous smoker? Y / N Quantity: _____ Start Date:_____/_____/_____

Please list all known allergies (please include type of reaction, location on body, and severity):

_____

_____

_____

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

P / F - Asthma
P / F - Hay Fever
P / F - Eczema
P / F - Other: _____
P / F - Basal Cell or Squamous Cell Carcinoma
P / F - Melanoma
P / F - Bleeding Disorders
P / F - Smoking
P / F - Diabetes
P / F - High Blood Pressure

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

_____

Please see reverse

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 birthday: _____/_____/_____ Insured's Soc. Sec. # _____-_____-_____
Mo. Day Year

Please read and sign below:

I authorize the release of the information in my medical record as necessary for my treatment, payment, and healthcare options.

I authorize payment of medical insurance benefits to BOUGHTON DERMATOLOGY, a division of Compass Dermatopathology, Inc. I understand that regardless of my insurance coverage, I am financially responsible for all medical services received.

I have received a copy of BOUGHTON 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.