Patient Information

Last Name_____ First_____ M_____

Address_____ City_____ State____ Zip_____

Date of Birth_____ Age _____ Sex ___M ___F Marital Status_____

Preferred Phone __(_____)_____ ___Cell ___ Home ___Work

Alternative Phone__(_____)_____ ___Cell ___ Home ___Work

Email_____ Employer _____

Emergency Contact_____ Relationship_____ Phone_____

Ethnicity_____ Primary Language_____ Decline to state _____

Responsible Party *(if different from patient)*

Last Name_____ First_____ Date of Birth _____

Address_____ City_____ State____ Zip_____

Relationship to Patient ____ Parent ____ Spouse ____ Child ____ Other_____

Insurance Information

Copayment $

Patient Medical History

Referring Physician_____ Family Physician_____

Check all that apply:

___Skin Problems-Past_____

___Skin Problems-Family History_____

___Melanoma-Family History_____

___Skin Cancer_____

___Cancer-Other_____

___Bleeding Tendency _____

___Scars & Keloid Scars_____

___Heart Disease_____

___Lung Disease _____

___Liver Disease _____

___High Blood Pressure_____

___Fainting or Seizures _____

___Diabetes_____

___Ulcers _____

___Surgery _____

___Other _____

Medication Allergies:

1. _____
2. _____

Patient Initials _____

Medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Patient Initials _____

Authorization for Medical Treatment & Financial Agreement

I AUTHORIZE MEDICAL PAYMENT TO DR. ERIC LEE(Pacific Bay Dermatology). I hereby consent to and authorize the performance of all treatments, surgery, and medical services by the physician and staff, which they may deem advisable and agree to pay all charges incurred by reason thereof. I also hereby authorize release of information requested and agree to pay all charges incurred by reason thereof and the authorization for release of information requested will continue until canceled by me in writing.

Patient Signature or Responsible Party _____ **Date** _____

Test Results to be notified to *(check all that apply)* ___Home Phone ___Work Phone ___Cell Phone

___Self ___Spouse ___Child ___Parent Other_____

Medicare Patients Only

Medicare Number _____ Name *(as it appears on card)*_____

I request the payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Eric and/or Stephen Lee (Pacific Bay Dermatology) for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. I understand my signature requests the payment be made and authorizes 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 release 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, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

Signature _____ Date_____