Walnut Creek Skin and Laser

Walnut Creek Office:
2255 Ygnacio Valley Rd. Suite B-1 Walnut Creek, CA 94598 Phone:925.945.7005
Brentwood Office:
350 John Muir Parkway, Suite 180 Brentwood, CA 94513 Phone: 925.308.9510
www.walnutcreekskinandlaser.com • Fax 925.945.7084

Dear Patient,

We look forward to seeing you at your upcoming appointment:

To expedite the process of the registration, please complete the attached registration forms.

1. Please complete all the forms in BLACK ink and bring them with you to your appointment.
2. You also may pre-register by sending in your packet via US mail or by fax prior to your appointment. Fax number is (925) 945-7084
3. If you do not pre-register please arrive at least 20 minutes prior to allow us adequate time to process your paperwork.
4. Please bring your Photo ID and Insurance Cards to the appointment.
5. For directions please visit our website at www.walnutcreekskinandlaser.com
6. Please enter the building through the “West Door”, our office is the first door on your left hand side.
7. Remember if you are unable to keep your appointment, please call us 24 hour business days ahead of your appointment, so another patient may utilize your appointment. Our practice charges a minimum of $25.00 (depending of the length of the appointment) for appointments that are not canceled in the 24 hour business day requirement and a minimum $40.00 no show fee (depending on length of appointment time.)

If you have any questions or concerns please feel free to call our office at the number above and we will be happy to assist you.

Sincerely,
Medical Staff
Walnut Creek Skin and Laser

Enclosure;

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Print Patient Name: _____ **DOB**: _____

Chief Complaint (summarize):_____

Past Medical History:
(Please place a mark on "Yes" or "No" to indicate if you have had any of the following):

Trouble Healing	[] Yes [] No	Develops Keloids/Hypertrophic Scars	[] Yes [] No
Bleeds Excessively	[] Yes [] No	Takes Aspirin/Anticoagulants	[] Yes [] No
Contact Derm to Tape	[] Yes [] No	Contact Derm to Antibiotic Ointment	[] Yes [] No
Frequent Skin Rashes	[] Yes [] No	Frequent Bacterial Infections	[] Yes [] No
Pacemaker	[] Yes [] No	Joints Implants	[] Yes [] No
Is Immunosuppressed	[] Yes [] No	Thyroid Disease	[] Yes []No
Diabetes	[] Yes [] No	NONE	[ ]

Difficulty with Oral Antibiotics: [] Nausea [] Headaches [] Yeast []NONE

Patient Skin History: [] NONE

Skin Cancer:	[] Yes [] No	Atopy (Hay fever, Asthma, Eczema)	[] Yes [] No
Psoriasis:	[] Yes [] No	Acne:	[] Yes [] No
Other:	[] Yes [] No	_____	

Family Skin History [] NONE

Father: Skin Cancer: Melanoma	[] Yes [] No	Basal/ Squamous Cell Carcinoma [] Yes [] No	Location: _____
Mother: Skin Cancer: Melanoma	[] Yes [] No	Basal/ Squamous Cell Carcinoma [] Yes [] No	Location: _____
Brother: Skin Cancer: Melanoma	[] Yes [] No	Basal/ Squamous Cell Carcinoma [] Yes [] No	Location: _____
Sister: Skin Cancer: Melanoma	[] Yes [] No	Basal/ Squamous Cell Carcinoma [] Yes [] No	Location: _____

Surgical History:
_____ Date _____/_____/_____
_____ Date _____/_____/_____

Pharmacy Name: _____**Location:**_____

Current Medications:	Strength	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: Reaction: [ ] No Known Drug Allergies (or list below)
_____ _____
_____ _____
_____ _____

Height: _____ **Weight**: _____ **Pain Level** (1-10) _____ **Pregnant:** [] Yes [] No [] N/A
Smoking Status: [] every day [] some days [] former smoker [] never
Alcohol: [] Yes [] No Describe Use: _____

CONSENT: I certify that the above information is true and correct to the best of my knowledge. I hereby authorize Walnut Creek Skin and Laser to administer and perform such procedures that may be deemed necessary in the diagnosis and treatment.
Patient/Guardian Signature: _____ Date: _____Initial _____

Patient Registration Information

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Name Last_____ First_____ MI_____
Address _____ City, State Zip_____ _____
Home _____ Cell _____ Cell Carrier _____
Email: _____

Emergency Contact: Name_____ Phone_____
Is it ok to release information to this person regarding your care? [ ] YES [] NO

Sex _____ DOB _____ Age _____ Marital Status _____
SSN _____ License _____

EMPLOYMENT INFORMATION (Fill out for parent or guardian if patient is a minor)
[ ] DISABLED [ ] UNEMPLOYED [ ] RETIRED
Occupation _____ Employer Name _____
Address _____ City, St Zip _____
Phone _____

PRIMARY CARE PROVIDER INFORMATION
Primary Care Provider _____ Phone _____
Referring Provider _____ Phone _____

The following information is a requirement by the federal government please visit www.cms.gov
LANGUAGE [ ] English [ ] French [ ] Chinese [ ] Spanish [ ] Japanese [ ] Farsi [ ] Italian
RACE: _____ ETHNICITY_____

INSURANCE *PLEASE COMPLETE THIS SECTION IN ITS ENTIRETY*

Primary
Insurance Name _____ Policy/Subscriber# _____
Group # _____ Relationship to Subscriber Self Spouse Child (please circle) Subscriber DOB _____

Secondary
Insurance Name _____ Policy/Subscriber# _____
Group # _____ Relationship to Subscriber Self Spouse Child (please circle) Subscriber DOB _____

Initial _____

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Print Patient Name: _____ Date of Birth: _____/_____/_____

Consent

I authorize the providers of Walnut Creek Skin and Laser to retain all of my medical records / information in an electronic format. These records will be maintained in a secured, confidential manner and shall be in compliance with HIPAA Regulations for patient confidentiality. These records shall not be released without consent of the patient or legal guardian. This authorization remains in effect until revoked in writing. I understand that I have been provided a copy of the Notice of Privacy Practices and that a full version is available and also posted in this office.

Signature: _____ Date: _____

Insurance Authorization and Assignment

I hereby authorize Walnut Creek Skin and Laser to furnish information to the insurance carrier(s) regarding my treatments. This authorization remains in effect until revoked in writing.

Signature: _____ Date: _____

Payment Obligations (see attached Practice Financial Policy)

I hereby assign, Walnut Creek Skin and Laser all payments for medical services rendered to myself or my dependents until revoked in writing. I understand that I am responsible for any amount not covered by my insurance at the time of service to include co-pays, deductibles and non-covered services. I also understand that if I do not fulfill my payment obligations to Walnut Creek Skin and Laser, my account will be subject to a full collections process. Any expenses related to the cost of collections and/or legal proceedings will be my responsibility. I acknowledge I have read a copy of the Practice's Financial Policy and that a copy will be made available for me to keep upon my request or I may retrieve it from www.walnutcreekskinandlaser.com .

Signature: _____ Date: _____

Medicare Patients Only

All Medicare patients must sign a lifetime beneficiary claim authorization. I request that payment of authorized Medicare benefits be made on my behalf to Walnut Creek Skin and Laser for any services furnished by my doctor. 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 or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of the medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the electronically submitted claims, physicians 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, co-insurance and non-covered services. Co-insurance and deductibles are based upon the charge determination of the Medicare carrier.

Signature: _____ Date: _____

NOTICE: Medical Doctors are licensed and regulated by the Medical Board of California, 1-800-633-2322 www.mbc.ca.gov.