

Dermatology Medical History

Patient: _____ Date of Birth: ___/___/___ Today's Date: ___/___/___

Reason for today's visit: _____

Are you allergic to any medications? YES NO If yes, list below:
 1. _____ 2. _____

Have you ever had dental anesthesia (Novocaine)? YES NO Any bad reaction? YES NO

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):
 1. _____ 3. _____ 5. _____
 2. _____ 4. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

	YES	NO		YES	NO
Lungs:			Other Systemic:		
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst/hunger	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Amputation	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
			Frequency/burning	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular:	YES	NO	Gastrointestinal		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Nausea, vomiting, diarrhea when taking antibiotics		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infection when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Limited motion	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of vein	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joint	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin: Have you ever had skin cancer? YES NO
 Has anyone in your family had melanoma? YES NO
 Do you have a history of any specific skin diseases? YES NO If yes, _____
 Do you have problems with healing? YES NO
 Do you develop keloids (scars) after surgery? YES NO
 Do you bleed easily? YES NO
 Do you develop skin rashes in reaction to: Medications Food Environment Bandages Neosporin
 Other _____

Social History:
 Do you drink alcohol? YES NO If YES _____ drinks per day
 Do you use IV drugs? YES NO If YES, what? _____ How often? _____
 Do you smoke? YES NO If YES, how much: _____
 Have you had or have you been exposed to HIV (AIDS)? YES NO

Please answer the following questions:
 (Women) Are you pregnant? YES NO Due Date: ___/___/___
 What is your occupation? _____ Hobbies? _____

Completed by:
 Patient _____ /___/___ _____ /___/___ _____
 Signed by Patient/Guardian Date Updated Initials
 Med. Assist _____ /___/___ _____ /___/___ _____
 Reviewed by Date Updated Initials

PATIENT INFORMATION New Patient Name Change Address Change Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS:

Today's Date ___/___/___

Name _____
Last First M.I.

Date of Birth: ___/___/___ Age: ___ Sex: Male Female SSN# Required: _____

ADDRESS:

Mailing Address _____
City State Zip

Home Phone: () _____ Work Phone: () _____

Cell Phone: () _____ e-mail: _____

PARENT, SPOUSE, OR RESPONSIBLE PARTY (if different from patient)

Name: _____ Date of Birth: ___/___/___
Last First M.I.

Address: _____
City State Zip

Home Phone: () _____ Work Phone: () _____

INSURANCE COVERAGE - PRIMARY:

Insurance Co. Name: _____

Address of Claim Center: _____

City State Zip Code

Name of Policy Holder (Insured): _____

Policy Holder (Insured) Date of Birth: ___/___/___

Policy #: _____ Group Name or #: _____

Policy Type: HMO PPO

If patient is child, check relationship to insured: Mother Father Other _____

INSURANCE COVERAGE - SECONDARY:

Insurance Co. Name: _____

Address of Claim Center: _____

City State Zip Code

Name of Policy Holder (Insured): _____

Policy Holder (Insured) Date of Birth: ___/___/___

Policy #: _____ Group Name or #: _____

Policy Type: HMO PPO

If patient is child, check relationship to insured: Mother Father Other _____

Please present your insurance card(s) and a photo ID to the receptionist along with this completed form. Thank you.

Referral information, Patient Financial Policy and Signature on File

Patient Name: _____ Today's Date ____/____/____

Other family members that are patients _____

Referred by: _____

Primary Care Physician _____ Phone () _____

EMERGENCY CONTACT INFORMATION:

In case of Emergency, who should be notified? _____ Phone () _____

Relationship to patient: _____

Do you give our office permission to discuss your medical information with family members?

YES NO If yes, please provide their names and phone numbers below.

Name: _____ Relationship: _____

Phone # (day): () _____ Phone # (evening): () _____

May we leave personal medical information on your answering machine or cell phone? YES NO

May we e-mail personal medical information to you? YES NO

E-mail address: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature _____ Date ____/____/____

PAYMENT POLICY:

HMO, PPO or other managed care patients: You will be responsible for paying your annual deductible, copayment and charges for any non-covered, cosmetic services at the time of service.

Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 50% of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patient or Responsible Party Signature _____ Date ____/____/____

Notice of Privacy Practices: Use and Disclosure of Health Information Protected under HIPAA

This document provides a summary of how medical information about you may be used and disclosed and how you obtain access to this information.

We understand that medical information about you and your health is personal. We care committed to protecting your medical information. It is our policy that the privacy of your health information be uncompromised while still allowing necessary access to assure that the medical care you receive is appropriate and of the highest possible quality.

We pledge to you that we protect the confidentiality of information provided to us. Your information will be used in the following manner, known as Treatment, Payment, and Healthcare Operations (TPO):

1. To provide medical treatment and/ or services.
2. To bill third party payers, when appropriate, for treatment you receive from us.
3. To facilitate the mechanisms which allow the operation of our facility.

In every use of your information, we will be responsible custodians of your PHI and adhere to the standards set forth in the legislation which created these privacy practices. We recognize that all patients have the right to privacy in all matters relating to their health and we will not use your PHI for uses outside of our facility without your express permission.

You have the following rights regarding to the medical information we maintain about you:

1. To inspect and copy information that may be used to make decisions about your care.
2. To request restrictions or limitations on the medical information we use or disclose about you for treatment, payment, or health care operations. While we are not required to agree to your request, we will do our utmost to comply unless the information is needed to provided emergency treatment
3. To amend the PHI we maintain if you believe that the medical information we have about you is incorrect or incomplete.
4. To request an accounting of disclosures we have made for uses other than your own.
5. To request confidential communications; i.e., that we communicate with you in a certain manner.
6. To receive a paper copy of his notice.

All members of our staff are committee to adhering to the conditions set forth in this notice of privacy practices. Any violation will be grounds for disciplinary action. We reserve the right to change this policy in the future; such changes will be available to all patients.

Should you believe that your privacy rights have been violated, you may file a complaint with this facility or with the State oversight department; all complaints must be submitted in writing. You will not be penalized for filing a complaint.

Patient acknowledgment:

I acknowledge receipt of this information regarding my rights to PHI privacy.

Signature: _____
Date: _____

I acknowledge the receipt of the Disclosure of information and Bill of Rights and Responsibilities.

Signature: _____
Date: _____

Dermatology and Laser Center
Michelle Ehrlich M.D.

Patient Release for Photography/Visual Recording

The undersigned, _____, a patient of Michelle Ehrlich M.D., consents to be photographed and/or visually recorded before, during and after treatment with the understanding that these visual recordings, still images, and adaptations may be used for professional and patient education and in certain medical and marketing materials, The identity of the patient shall not be revealed in photography used for medical, educational or scientific research purposes under the authority of the Operative Permit or Consent to Photograph form, or in any accompanying descriptive texts.

Yes

No

The undersigned grants Dermatology and Laser Center and the office of Michelle Ehrlich MD the ongoing and unrestricted right to the use of these images and acknowledges that he/she relinquishes all rights, title, and interest in these materials, or any right to profit or gain directly or indirectly realized through the use of these materials.

Yes

No

This form and the effect of my consent have been fully explained to me and any questions have been fully answered to my satisfaction.

Patient Signature

Date

Witness Signature

Date

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____
Patient's or Patient Representative's Signature (Date)

By: _____
Physician's or Authorized Representative's Signature (Date) By: _____
Print Patient's Name

Print or Stamp Name of Physician,
Medical Group or Association Name

(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to Patient. Original is to be files in Patient's medical records.