Alta Dermatology Medical Group

7365 Carnelian Street, Suite 137

Rancho Cucamonga, CA 91730

909-948-8888

PATIENT (LEGAL) NAME: ______________________

DATE OF BIRTH: ______________ AGE: __________ GENDER: M F

SSN: ______________ EMAIL ADDRESS: ______________

STREET: ______________________

CITY: ______________ STATE: ________ ZIP: __________

HOME PHONE: ______________ CELL PHONE: ______________

MARITAL STATUS: M S D W SPOUSE: ______________

EMERGENCY CONTACT: ______________ PHONE #: ______________

RESPONSIBLE PARTY FOR BILL: ______________ SSN: ______________

STREET: ______________ DATE OF BIRTH: ______________

CITY: ______________ STATE: ________ ZIP: __________

EMPLOYER: ______________ WORK PHONE: ______________

How did you hear about us? Yellow pages ______ Web ______ Other ______________

Family ______________ Friend ______________ Physician ______________

INSURANCE INFORMATION

PRIMARY	SECONDARY
NAME: ______________	NAME: ______________
ID #: ______________	ID #: ______________
GROUP#: ______________	GROUP # ______________
SUBSCRIBER NAME: ______________	SUBSCRIBER NAME: ______________
SUBSCRIBER DOB: ______________	SUBSCRIBER DOB: ______________

I, the undersigned, assign directly to Alta Dermatology Medical Group all surgical and /or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits.

Signature ______________________ Date ______________________

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)

Lungs:	YES	NO
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Morning Cough	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐

Cardiovascular:	YES	NO
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Phlebitis	☐	☐
Inflammation of vein	☐	☐
Blood clots	☐	☐
Pacemaker	☐	☐

Other Systemic:	YES	NO
Diabetes	☐	☐
Excessive thirst/hunger	☐	☐
Amputation	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Dialysis	☐	☐
Bladder	☐	☐
Frequency/burning	☐	☐
Gastrointestinal		
Stomach absorptive disorder	☐	☐
Nausea, vomiting, diarrhea when taking antibiotics	☐	☐
Yeast infection when taking antibiotics	☐	☐
Arthritis/Joint Deformity	☐	☐
Arthralgia	☐	☐
Limited motion	☐	☐
Artificial joint	☐	☐
Convulsions, Epilepsy or Seizures	☐	☐
Fainting	☐	☐

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 skin cancer? ☐ 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 ☐ Topical 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 ☐ Medical Assistant ________ Initials

______________________ Signed by Patient ___/___/___ Date

______________________ Reviewed by ___/___/___ Date

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ACKNOWLEDGEMENTS/DISCLOSURES

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PATIENT NAME

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Can confidential messages be left on your answering machine or voicemail?
2. YES NO
3. Please list, if any, person(s) whom we may inform about your general medical condition, your diagnosis, And/or your payment option

NAME____________________________PHONE NUMBER____________________________

NAME____________________________PHONE NUMBER____________________________

ASSIGNMENT OF BENEFITS:

I assign all insurance benefits to Dr. Griffith. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that Dr. Griffith's office is not responsible to know my plan, what it will pay or the deductible requirements. I hereby give my consent to examination, treatment and insurance billing.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE PRIVACY PRACTICES:

I hereby acknowledge that a copy of this medical Practice's Notice of Privacy Practices is available and posted in the Reception area and will be given a copy upon request.

Please be advised that we accept Medicare. We DO NOT ACCEPT MEDI-CAL. I acknowledge that I am responsible for All charges not paid by Insurance/Medicare. Please be advised that we ONLY ACCEPT HMO INSURANCE WITH PRIMARY CARE ASSOC. OR REGAL MEDICAL GROUP. + IEHP

COSMETIC VISITS: If you are here for cosmetic purposes and inquire about dermatology issues during treatment, your Insurance will be billed accordingly. You are financially responsible for all charges whether or not paid by insurance. Please be advised that we charge $35.00 if you miss your appointment or fail to cancel 24 hours prior to the appointment.

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California, (800) 633-2322, www.mbc.ca.gov

Signature____Date______________________

Patient/Responsible Party

Print Name____

If not signed by the patient, please indicate:

Relationship____

HIPPA Privacy Rule of Patient Authorization Agreement

Dr. Jack Griffith

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (s164.508(a)

I,____________________(Patient Name) understand that as part of my health care, Dr. Jack Griffith, originates and maintains health records describing my health history, symptoms, examination, and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among health professionals who may contribute health care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided;
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the **NOTICE of Privacy Practices** that provides a more complete description of information uses and disclosures.

I understand that as of my care and treatment it may be necessary to provide my Protection Health information to another covered entity. I have the right to review Dr. Jack Griffith's notice prior to signing this authorization. I authorize that disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (s164.506(a))

- I have the right to review Dr. Jack Griffith's Notice of information Practices prior to signing this consent;
- That Dr. Jack Griffith reserves the right to change the notice and practices and the prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Dr. Jack Griffith is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that Dr. Jack Griffith has already taken actions in reliance thereon.

Signature of Patient or Legal Representative Witness X____

Printed Name of Patient or Legal Representatives Witness X____

HIPPA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

Dr. Jack Griffith

Acknowledgement of receipt of information Practices Notice)s164.506(a))

I,______________________________(Patient's Name) understand that as part of my health care, Dr. Jack Griffith originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided a complete description of the uses and disclosures or my health information. I understand that:

- I have the right to review Dr. Jack Griffith's Notice or Privacy Practice prior to signing this acknowledgement;
- That Dr..Jack Griffith reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness X____

Printed Name of Individual or Legal Representative Witness X____

Date:__________________________________

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- Individual refused to sign
- Communication barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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