Escondido Dermatology Inc. 504 W. Mission Avenue, Suite 101, Escondido, CA 92025
(760) 747-1980 (760) 747-2045 Fax

PLEASE PRINT

DATE ______________________________________ REFERRING M.D.______________________

NAME OF PATIENT ____________________________ SEX___ AGE ________ S.S.#______________

DATE OF BIRTH ______________________________ MARITAL STATUS ☐S ☐M ☐D ☐W

ADDRESS ____________________________________ CITY ___________________ STATE________

ZIP CODE ___________ PHONE # ___________ NAME OF SPOUSE OR PARENT_______________

PATIENT'S OCCUPATION ______________________ EMPLOYER______________________________

WORK ADDRESS _______________________________ WORK PHONE #__________________________

NEAREST RELATIVE OR FRIEND AND PHONE #____

PERSON RESPONSIBLE FOR PAYMENT____

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE COMPANY____

SUBSCRIBER OF PRIMARY INSURANCE _________________ EMPLOYER____________________

WORK PHONE # OF SUBSCRIBER________________ SUBSCRIBER S.S #_____________________

CERTIFICATE # __________________ GROUP # __________ MEDICARE # __________________

PRIMARY SUBSCRIBER'S DATE OF BIRTH __________________________________ SEX__________

NAME OF SECONDARY INSURANCE COMPANY____

SUBSCRIBER OF SECONDARY INSURANCE_______________ EMPLOYER______________________

WORK PHONE # OF SUBSCRIBER ________________ SUBSCRIBER S.S #_____________________

CERTIFICATE# __________________ GROUP# ___________ DATE OF BIRTH__________________

IS PATIENT EMPLOYED? __________ PART TIME STUDENT? ____________ FULL TIME?_________

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies or staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR YOUR PART OF THE CHARGES. WE ACCEPT VISA AND MASTERCARD FOR YOUR CONVENIENCE. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes Escondido Dermatology to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to Escondido Dermatology Inc. when an assigned claim is filed.

Signature of Patient or Legal Guardian ______________________ Date __________

Name of policy owner if other than patient: ____

Patient relationship to policy owner: ☐ Self ☐ Child ☐ Spouse ☐ Other

ESCONDIDO DERMATOLOGY INC.

Escondido Dermatology Inc. 504 W. Mission Avenue, Suite 101, Escondido, CA 92025
(760) 747-1980 (760) 747-2045 Fax

LIST ANY MEDICAL CONDITIONS YOU ARE BEING TREATED FOR (INCLUDING PREGNANCY)

____

____

LIST PRESENT MEDICATIONS (PRESCRIPTION AND NON-PRESCRIPTION)

____

____

LIST ANY SKIN MEDICATIONS YOU HAVE BEEN USING

____

____

LIST ANY MEDICATIONS YOU CANNOT TAKE INTERNALLY (PILLS OR INJECTIONS)

____

____

LIST ANY MEDICATIONS OR SUBSTANCES WHICH CAUSE A RASH WHEN APPLIED TO YOUR SKIN

____

____

IS THERE A FAMILY HISTORY OF: **PUT CHECK BOX(ES) ONLY IF YES**

☐ **CHILDHOOD ECZEMA** ☐ **ASTHMA** ☐ **HAYFEVER**

☐ **DIABETES** ☐ **PSORIASIS** ☐ **TUBERCULOSIS**

☐ **SKIN CANCERS** ☐ **OTHER SKIN DISEASES**

DO YOU HAVE OR HAVE YOU EVER HAD: **PUT CHECK BOX(ES) ONLY IF YES**

☐ **ARTHRITIS** ☐ **ASTHMA** ☐ **CANCER**

☐ **CHILDHOOD ECZEMA** ☐ **DIABETES** ☐ **DIVERTICULITI**

☐ **EPILEPSY** ☐ **FAINTING EPISODES** ☐ **FREQUENT SKIN INFECTIONS**

☐ **GLAUCOMA** ☐ **HAYFEVER** ☐ **HIGH BLOOD PRESSURE**

☐ **HIVES** ☐ **KIDNEY DISEASE** ☐ **LIVER DISEASE OR JAUNDICE**

☐ **TUBERCULOSIS** ☐ **POSITIVE TB SKIN TEST** ☐ **PSORIASIS**

☐ **MENTAL OR EMOTIONAL DISTURBANCES** ☐ **STOMACH OR DUODENAL ULCER** ☐ **VENERAL DISEASE OR POSITIVE BLOOD TEST**

DO YOU TAKE ASPIRIN ON A REGULAR BASIS? ☐ **YES** ☐ **NO**

DO YOU TAKE ANY BLOOD THINNERS? ☐ **YES** ☐ **NO**

LIST ANY SURGERIES THAT YOU HAVE HAD? ☐ **YES** ☐ **NO**

ESCONDIDO DERMATOLOGY INC.