WELCOME TO OUR OFFICE

2221 Balfour Road • Suite A • Brentwood, CA 94513
Bus: (925) 240-9116 • **Fax:** (925) 240-9117
www.SkinQuestion.com

Please assist us by accurately completing all information. Your information will remain strictly confidential and aid us in medical treatment and accurate filing of insurance. We offer insurance billing as a courtesy. You will be responsible for the deductibles, rules and regulations of your insurance.

PLEASE PROVIDE YOUR DRIVERS LICENSE AND INSURANCE CARD

Federal regulation requires a photo ID along with insurance card.

PATIENT INFORMATION:

Today's Date_____

Patient's Full Name_____ Marital Status ❒ S ❒ M ❒ W ❒ D

SSN #_____ Birthdate_____ Age_____ Sex ❒ Male ❒ Female E-mail_____

Street Address_____ City_____ State_____ Zip Code_____

Patient's Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Employer_____ Employer Address_____ Occupation_____

MEDICAL INFORMATION:

Family Doctor_____ Last Visit_____

Referring Doctor_____ Last Visit_____

Preferred Pharmacy_____ Location_____

EMERGENCY CONTACT INFORMATION:

Name_____ Phone (____) _____ Alternative Phone (____) _____

Relationship_____

FINANCIAL RESPONSIBILITY:

❒ Please process insurance claims on my behalf. I understand that I am responsible for all charges regardless of my insurance coverage.

❒ I will pay privately at each visit.

INSURANCE: *Information needed to process your claim.*

❒ **CO-PAY $**_____ (if not stated on card)

Insured (Subscriber)_____ Insured's Date of Birth_____

Insured's Relationship to Patient_____ Insured's Social Security _____

(some insurances require SS#)

Complete below ONLY if Patient is a Minor:

Who is responsible for account : ❒ Father ❒ Mother ❒ Other_____

❒ **Address+Phone same as above** (continue next form)

Address+Phone Different (Please complete below)

Father's Name_____ DOB_____

Father's Address_____

Father's Employer_____

Home Ph.(____)_____ Work Ph.(____)_____

❒ **Address+Phone same as above** (continue next form)

Address+Phone Different (Please complete below)

Mother's Name_____ DOB_____

Mother's Address_____

Mother's Employer_____

Home Ph.(____)_____ Work Ph.(____)_____

Balfour Dermatology

HIPAA - FINANCIAL – OFFICE POLICY

We appreciate your confidence in choosing our office.

Privacy: We share your medical information with Delta Medical Billing, UCSF, Pathlogic and other professional agencies to obtain the best service possible for you. You may waive your right to privacy and authorize our office to give any and all medical information to a person(s) you designate below; including all diagnosis, HIV, lab/pathology results, billing/insurance questions, medications, plus any other information not specified.

☐ **AUTHORIZED to receive ALL medical information:** _____

Your Designee or "None"

Insurance: As a courtesy to our patients, Balfour Dermatology will bill your insurance. We utilize a separate billing service, **Delta Medical Billing,** to process claims on your behalf. We try our best, but due to ever changing insurance policies we do not offer any guarantee of payment or coverage. You are fully responsible for all charges regardless of your insurance's coverage.

Co-payments/Coinsurance/Annual Deductibles: You are responsible for your co-insurance, out-of-network portion and/or annual deductible at time of service.

Checks: We cannot accept a check for over $100. Return check fees are $50.

Cancellation Fees: CANCELLATIONS REQUIRE 24 HR NOTICE, to avoid **FEE $75**

RX Refills: PLEASE CALL YOUR PHARMACY. If it's been over a year since we've seen you; please call us for an appointment.

RX Prior Authorizations: We will be happy to transfer your RX to a pharmacy that will manage this time consuming process.

Office Etiquette: Please be courteous and respectful to other patients and our staff. We reserve the right to refuse service to anyone. You are encouraged to speak with our office manager if you have any concerns or praises.

I acknowledge that I have read and understand the policies of Balfour Dermatology. I understand that I have the right to refuse to sign this document, but the office policies still apply. Please let us know if you'd like a copy of this for your records.

Your Signature: _____ Date: _____

(Patient or Guardian for Minor)

MEDICAL HISTORY

To help evaluate your present, past and future health concerns.

PLEASE COMPLETE THE FOLLOWING MEDICAL HISTORY FORM.

Name_____ Date_____

Age:_____ Sex: ❒ M ❒ F Referred By: ❒ self/friend ❒ Dr. (name)_____

Reason for today's visit:_____ ❒ Skin Cancer Monitoring CC

Symptoms of today's problem:_____ HPI

Skin areas involved:_____ LOCATION

How long has the problem been present?_____ DURATION

Was there any previous treatment? ❒ Yes ❒ No When?_____ Type?_____ TIMING

Was a biopsy done? ❒ No ❒ Yes ❒ biopsy done by referring Dr. ❒ Other_____ CONTEXT

CHECK ALL THAT APPLY TO TODAY'S PROBLEM

SYMPTOMS: ❒ itching ❒ tingling ❒ pain ❒ bleeding ❒ infection ❒ other_____ **QUALITY:** ❒ Intense ❒ Intermittent

What medications, including creams have been prescribed for your condition?_____

_____ MODIFYING FACTOR

Which of these are you currently using?_____

Which "over the counter" medications have you used?_____

Which of these are you currently using?_____

Which brand of bath soap are you currently using?_____

SYSTEM REVIEW: Check all that apply regarding your health and add any other important problems.

Allergies to Medication: ❒ none ❒ list:_____

Current Medications:_____

Skin
❒ abnormal scarring
❒ poor healing
❒ other skin disorders
_____

Cardiovascular
❒ normal
❒ angina
❒ artificial heart valve
❒ pacemaker
❒ hypertension
❒ heart attack (when?)_____

Neurological
❒ normal
❒ stroke
❒ seizures
❒ other:_____

Hematologic/Lymphatic
❒ normal
❒ anemia
❒ bleeding problems
❒ enlarged lymph nodes

Respiratory
❒ normal
❒ asthma
❒ emphysema
❒ other lung problems
_____

Psychiatric
❒ normal
❒ depression
❒ anxiety attacks
❒ other:_____

Constitutional Symptoms
❒ none
❒ weight loss
❒ fever
❒ other:_____

Gastrointestinal
❒ normal
❒ stomach ulcer
❒ colitis
❒ liver damage
❒ other GI problems:_____

Endocrine
❒ normal
❒ diabetes
❒ thyroid
❒ kidney disease_____

Eyes/Ears/Nose/Throat
❒ normal
❒ glaucoma
❒ hearing aid
❒ plastic surgery

Musculoskeletal
❒ normal
❒ arthritis
❒ artificial joint
❒ other:_____

Infections
❒ none
❒ hepatitis
❒ HIV/AIDS
❒ tuberculosis (T.B.)
❒ other:_____

PAST HISTORY

Previous Skin Cancer: ❒ none ❒ list location(s):_____

Major illnesses or Hospitalizations:_____

FAMILY HISTORY

Skin Cancer: ❒ none ❒ melanoma ❒ basal cell ❒ squamous cell ❒ List:_____

SOCIAL HISTORY

Occupation:_____ Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widow

Previous sunlight exposure or sunburns: ❒ mild ❒ moderate ❒ extensive ❒ tanning bed use ***Do you wear?:*** ❒ dentures ❒ glasses ❒ contact lenses

Do you Smoke?: ❒ no ❒ former ❒ yes, packs per day_____ ***Alcohol:*** ❒ no ❒ social/occasional drinking only

Alcohol or drug problems/addictions: ❒ no ❒ yes, describe:_____

Reviewed:

DO YOU HAVE ANY COSMETIC SKIN CONCERNS?

Do you want to learn more about the best practices for caring for your skin?

Circle Any that Apply

- Learn about **Basic Skin Care**? YES
- Learn about **Anti-Aging & Wrinkle** treatments? YES
- Learn about removing **Brown Spots & Sun Damage**? YES
- Get Information on **Hair Removal**? YES
- Learn about **Acne Scarring** treatments? YES
- Investigate non-medical **Acne** treatments? YES
- Learn about **Skin Tags**? YES
- Learn about **Excessive Sweating** treatments? YES
- Get information on **Botox**? YES
- Learn about **Chemical Peels** and **Microderms**? YES
- Need info on **Reducing Redness** or **Unsightly Veins**? YES

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Balfour Dermatology

Show any staff member that you've liked us on Facebook for a Free sample product.

If you prefer monthly emails on our Special Offers please provide your email address.

_____ _____

your e-mail *your name*

For additional discounts on Botox, Skincare, Juvederm &Voluma

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