Welcome to our office! Thank you for choosing O.C. Dermatology & Surgery. We are a full-service dermatology practice whose priority is delivering high-quality, ethical care. Our knowledgeable staff aims to create a friendly, positive atmosphere for our patients and takes pride in serving our patients.

At OC Dermatology & Surgery, you will be seen by only board-certified dermatologists. We believe this is essential to delivering high-quality care. All of our doctors (Dr. Soni, Dr. Fulwider, Dr. Eragi, & Dr. Choudhry) are extensively trained in medical, surgical, and cosmetic dermatology. Additionally, Dr. Soni and Dr. Fulwider are highly trained and experienced in Mohs micrographic surgery. We believe in spending the time necessary to educate and provide patients with the highest level of care, thereby maximizing outcomes. When it comes to skin cancers, all our dermatologists are firm believers of early detection by means of routine, thorough skin exams with digital photography and dermoscopy. And when a skin cancer needs to be treated, we do so with skill, compassion, and many times painless (or almost painless) procedures. Artists both in and out of the office, our doctors use their artistic eye both 1) to maximize the cosmetic outcome of reconstructive surgery after skin cancer removal and 2) to help patients achieve a more youthful, healthy look.

Enclosed are the following forms (4) for you to review and complete at your convenience prior to your scheduled appointment: 1) patient registration form; 2) office policies; 3) notice of privacy practices & acknowledgement of receipt; & 4) medical history form.

We kindly ask that you arrive 15 minutes prior to your scheduled appointment time and that you bring 1) the completed forms, 2) your insurance card(s), and 3) an official photo ID (e.g. driver's license). We look forward to seeing you and appreciate the trust you have placed in us regarding your care.

Sincerely,

Orange County Dermatology & Surgery

*Note: Google Maps, Mapquest, and most GPS tracking systems incorrectly map the address.
PLEASE NOTE THE FOLLOWING ACCURATE DIRECTIONS:

<u>From the North</u>
Take the I-405 South
Take the Beach Blvd/CA-39 exit (Exit 16).
Take the 1st ramp toward Huntington Beach.
Turn left onto Center Ave.
Turn right onto Beach Blvd/CA-39
Turn left onto Newman Ave…

<u>From the South</u>
Take the I-405 North
Take the Brookhurst St exit (Exit 14).
Take the Brookhurst St. South ramp.
Turn right onto Talbert Ave.
Turn right onto Beach Blvd/CA-39 North.
Turn right onto Newman Ave…

<u>From the East</u>
Take Beach Blvd/CA-39 South.
Turn left onto Newman Ave…

<u>From the West</u>
Take Beach Blvd/CA-39 North.
Turn right onto Newman Ave…

…Pass the parking structure and brick & glass building on your right-hand side.
Turn right into the hospital parking lot.
You will see the front entrance to the brick & glass building, where we are located.

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DERMATOLOGY & SURGERY

PATIENT INFORMATION *Please present your driver's license at the time of check-in.*

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

Mailing Address: St _____ City _____ State _____ Zip _____

May we mail information related to your care to the mailing address above? Y N

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow

Home Phone (_____)_____ ☐ Preferred May we leave a message with your health information? Y N

Cell Phone (_____)_____ ☐ Preferred May we leave a message with your health information? Y N

E-mail: _____ May we e-mail you occasional practice or educational updates? Y N

Driver's License # _____ State _____ Social Security #_____-_____-_____

Employer _____ Occupation _____ Work (_____)_____x_____ OK to call? Y N

Employer Address: St _____ City _____ State _____ Zip _____

Spouse: Name _____ Phone (_____)_____ May we discuss your health information? Y N

INSURANCE - PRIMARY: *Please present insurance card at the time of check-in.* ☐ No Insurance

Insurance Name _____ Subscriber # _____ Group# _____

Address: St _____ City _____ State _____ Zip _____

Who is the policy holder? ☐ Patient ☐ Spouse ☐ Parent/Guardian *If not the patient, please complete INSURED INFO below.*

INSURANCE - SECONDARY: *Please present insurance card at the time of check-in.*

Insurance Name _____ Subscriber # _____ Group# _____

Address: St _____ City _____ State _____ Zip _____

INSURED INFORMATION *Please complete if insured is other than the patient (e.g. spouse, parent, guardian).*

Name _____ Date of Birth _____/_____/_____ Social Security _____-_____-_____

Address: St _____ City _____ State _____ Zip _____

Home Phone (_____)_____ Cell Phone (_____)_____ Gender: ☐ Male ☐ Female

Employer _____ Occupation _____ Work (_____)_____x_____

Employer Address: St _____ City _____ State _____ Zip _____

PRIMARY CARE PHYSICIAN _____ Phone (_____)_____

PHARMACY OF CHOICE _____ Phone (_____)_____

St/Cross St _____ City _____ State _____ Zip _____

HOW DID YOU FIND OUT ABOUT US? A) A friend referred me. Who? _____ B) A doctor referred me. Who? _____ C) through my insurance company. How? _____ D) other: _____

EMERGENCY CONTACT (not living with you)

Name _____ Relationship _____ Phone (_____)_____

I understand that the physicians are licensed and regulated by the Medical Board of California.
(800) 633-2322 www.mbc.ca.gov

_____ _____ _____

SIGNATURE: Patient Parent Guardian Conservator **PRINT NAME** **DATE**
(please circle one)

If the person signing this form is the patient's parent, legal guardian, or conservator, please complete the following:

Name:_____ Date of Birth _____/_____/_____ Gender: M F

Home Phone (_____)_____ Cell Phone (_____)_____ Work Phone (_____)_____

Reviewed by _____

DERMATOLOGY & SURGERY

OFFICE POLICIES

Thank you for choosing O.C. Dermatology & Surgery (OCDS). Accurate information will allow us to give you the best possible care. Your health care is our priority. Thank you for partnering with us in your care.

FINANCIAL

► Payment is due for all services at the time they are rendered unless you are in a prepaid plan in which we participate. We accept payment in the form of cash, check, or credit card.

► You are financially responsible for all charges regardless of isurance coverage. You agree to pay applicable finance charges and collection costs on all past due accounts.

► **Non-covered / Cosmetic Services**. Charges for any services not covered by insurance and for cosmetic procedures are due and payable at the time of service.

► **Non-sufficient Funds (NSF).** For each check that is returned to OCDS because of non-sufficient funds, you will be re-billed for the original check amount as well as NSF fee of $25.

► For all patients with a PPO or other managed care plan with which OCDS is a participating provider:

- **Insurance Information**. At the time of service, you must provide a current insurance card with accurate information. It is your responsibility to know and to understand your insurance benefits. Charges from claims that are denied due to inaccurate information will become your responsibility.
- **Co-payments**. Co-payments and applicable deductible amounts are due at the time of service.
- **Medi-Cal**. OCDS is not a Medi-Cal provider.
- **HMO**. OCDS is not contracted with any HMO's. You will be considered a "non-covered" patient.
- **Medicare**. OCDS is a participating provider of Medicare but does not accept any Medicare HMO plans.
- **Assignment of Benefits**. I hereby authorize my insurance company(s) to pay any medical insurance benefits due directly to "Vipal Soni M.D., Inc." or its dba "Orange County Dermatology & Surgery".
- **For Medicare patients only**. *I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries any information needed for this or a related Medicare claim. Regulations pertaining to Medicare assignment of benefits apply.*

GENERAL

► **Lab Results**. It is standard procedure for our office to notify patients of all laboratory results including blood work, cultures, and pathology results. We ask our patients to share in the responsibility of obtaining their laboratory results by calling the office if not notified after a reasonable time period (e.g. 3-4 weeks for biopsy results, 7 days for culture results, and 2 weeks for routine blood work). During your visit, you will be notified of what (if any) tests are done.

► **Prescription Refill Requests**. Refill requests must be faxed from your pharmacy and may take approximately 5-7 business days. Your doctor may not refill your prescription for a variety of reasons including not having been seen within one year. New prescriptions require an office visit with your doctor.

► **Medical Records**. If you would like a copy of your medical records from us, please submit a letter of request / authorization with an original signature to our office. You will be charged $15 - $30 for this service depending on the size of your medical chart. Please allow 15 days from the day we receive your request.

► **Missed Appointments or Surgeries**. If you miss a scheduled appointment and do not notify the office at least 24 hours in advance, an administrative fee of $50 will be charged to your account. If you are scheduled for Mohs surgery or an excision and miss your scheduled procedure without notifying the office at least 72 hours in advance, you will be charged an administrative fee of $100. These fees are not covered by insurance and therefore will not be billed to your insurance company. We appreciate your understanding in this matter.

► **Collections**. If your account is in collections, you are considered dismissed from the practice.

By signing below, I acknowledge that I have read, understand, and agree to all the policies listed above. I permit a copy of this authorization to be used in place of the original.

_____ _____

Signature: (please circle one) Patient Parent Legal Guardian Conservator **Date**

_____ _____

Print Name If signing as a parent or guardian, please note patient name

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DERMATOLOGY & SURGERY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that I am aware that a copy of the current notice is posted in the reception area and that a copy of any amended Notice of Privacy Practices will be available at each appointment as well as on the practice website.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ parent or guardian of minor patient

☐ guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

_____

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: _____

DERMATOLOGY & SURGERY

Patient Name: _____ **Date**: _____

Females: Are you pregnant? Yes No Are you planning to become pregnant? Yes No

MEDICATIONS(current):

ALLERGIES: (e.g. meds, latex, tape)

Review of Systems - Do you currently have or have you previously had any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Skin cancer: _____	☐	☐	**SKIN** Easy bleeding	☐	☐	Rashes:
☐	☐	Problematic/slow healing	☐	☐	Keloids / thick scars	Other:		
		ENT			**GI**			**HEMATOLOGIC**
☐	☐	Glaucoma	☐	☐	Heartburn	☐	☐	Ankle/foot swelling
☐	☐	Itchy eyes	☐	☐	Ulcers	☐	☐	Varicose veins
☐	☐	Ear infections	☐	☐	Liver disease / Hepatitis	☐	☐	Blood clots
☐	☐	Sinus trouble	☐	☐	Gallstones	☐	☐	Frequent/excessive bleeding
☐	☐	Nosebleeds	☐	☐	Irritable bowel	Other:		
☐	☐	Mouth sores	Other:					
Other:								**ENDOCRINE**
					GU	☐	☐	Diabetes mellitus
		RESPIRATORY	☐	☐	Incontinence	☐	☐	Thyroid disease
☐	☐	Shortness of breath	☐	☐	Frequent urination	Other:		
☐	☐	Wheezing	☐	☐	Kidney Stones			
☐	☐	Asthma	☐	☐	Dialysis			**PSYCHIATRIC**
☐	☐	Bronchitis	Other:			☐	☐	Stress/anxiety
Other:			Age at menopause:			☐	☐	Depression
						☐	☐	Thoughts of suicide
		CARDIOVASCULAR			**MUSCULOSKELETAL**	Other		
☐	☐	Chest pain	☐	☐	Chronic back pain			
☐	☐	High blood pressure	☐	☐	Osteoarthritis			**MALIGNANCY**
☐	☐	Low blood pressure	☐	☐	Rheumatoid arthritis	☐	☐	Cancer:
☐	☐	Irregular heartbeat	☐	☐	Lupus	Treatment:		
☐	☐	Heart attack	☐	☐	Calf pain			
☐	☐	Heart murmur	Other:					**INFECTIONS**
☐	☐	Cardiac surgery				☐	☐	Fever blisters/cold sores
☐	☐	Mitral valve prolapse			**NEUROLOGIC**	☐	☐	Herpes, location
☐	☐	Artificial heart valve	☐	☐	Seizures/Epilepsy	☐	☐	Shingles
☐	☐	Pacemaker	☐	☐	Stroke	☐	☐	Chickenpox
☐	☐	Phlebitis	☐	☐	Headaches/Migraines	☐	☐	Hepatitis (B or C)
☐	☐	High cholesterol	☐	☐	Alzheimer's disease	☐	☐	Tuberculosis / +PPD
Other:			Other:			☐	☐	HIV
						Other		

Yes	No	**Social History**:
☐	☐	Do you drink alcohol?
☐	☐	Do you smoke tobacco?
☐	☐	Do you use IV drugs?

Surgeries: (including cosmetic procedures) Date

Occupation: Hobbies/leisure activities:

Yes	No	**Family History**:
☐	☐	Does any 1st degree relative (parents, siblings, children) have skin cancer? If so, please explain:
☐	☐	Does any 1st degree relative have allergies, hay fever, asthma, eczema? Explain:
☐	☐	Does any family member have any other skin diseases? Explain:

Patient Signature: _____ **Date**: _____

Medical History Form Reviewed by: _____ **Date**: _____

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