YORBA LINDA
DERMATOLOGY

Patient Registration

Last Name: _____ First Name: _____ M.I _____ Sex: ☐ M ☐ F

DOB: _____ Age: _____ Social Security # _____

ADDRESS:

Address: _____

City: _____ State: _____ Zip Code: _____

PHONE:

Home: _____ Preferred number: ☐ Home ☐ Cell ☐ Work

Mobile: _____ May we leave a detailed message? ☐ Yes ☐ No

Work: _____ May we text appointment reminders? ☐ Yes ☐ No

EMAIL:

Email address: _____

May we email appointment reminders? ☐ Yes ☐ No

Would you like to be notified of promotions and events? ☐ Yes ☐ No

CONSENT TO DISCUSS CARE:

If you are 18 years or older we cannot discuss your care with other family members, spouses or caretakers without your consent. Do you authorize consent for any other individuals? ☐ Yes ☐ No

If yes: _____ Relationship: _____ Phone Number: _____
Name

DEMOGRAPHICS:

Ethnic Group:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

Race:
☐ White
☐ American Indian / Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian / Pacific Islander
☐ Other

PRIMARY CARE PHYSICIAN:

Name: _____ City: _____

REFERRAL:

How did you hear about us? _____

PHARMACY:

Preferred pharmacy: _____ City: _____

****Please Complete Both Sides**

INSURANCE INFORMATION

ELIGIBILTY: Please be aware that your health insurance policy is a contract between you and your insurance company. It is an agreement that your insurance will pay for covered medical services as long as your premiums are paid. Because they may not pay for every service, you will be responsible for any non-covered charges. We will verify your eligibility before your visit but please keep in mind that a determination of benefits with your carrier is NOT a guarantee of payment.

DEDUCTIBLES: Before your visit, we will verify your deductible and/or co-pay amounts. If your annual deductible for the calendar year has not been met, you will be responsible for any charges incurred during your visit, payable at the time of service. We will also collect any co-pay amounts at the time of service.

OUTSIDE SERVICES: Please be aware that your care may require the use of laboratory or pathology evaluation. These studies are not performed at our practice so please understand that you will receive a separate bill from the pathologist or laboratory proving those services. If you have a preference for a specific facility, please notify us prior to any procedure so that we can do our best to accommodate you.

I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for the services provided. I also authorize Yorba Linda Dermatology or my insurance company to release any information required to process my claim.

Signature: _____ **Date:** _____
Patient or Legal guardian

Printed name of Legal guardian: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of Yorba Linda Dermatology's Notice of Privacy Practices

Signature: _____ **Date:** _____
Patient or legal guardian

CONSENT FOR TREATMENT

I understand that many dermatological conditions are chronic and require ongoing care. All medications have side effects and there are risks to any medication prescribed. Dermatologists frequently diagnose skin growths by performing a skin biopsy and treat skin growths by freezing, cauterization, and/or cortisone injection. I understand that there are risks to any procedure and that these risks include, but are not limited to:

- Temporary or permanent discoloration
- Scarring
- Pain
- Infection
- Bleeding
- Nerve damage

I consent to having these procedures done as part of my care and treatment. I also have the right to refuse any treatment at any time. This authorization and consent shall remain in effect for this visit and all future visits to the office.

By signing below, I authorize evaluation and treatment by the providers at Yorba Linda Dermatology.

Signature: _____ **Date:** _____
Patient or legal guardian

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