Phone: (805) 434-2821
Fax: (805) 434-2526

PLATEROTI Dermatology

1101 Las Tablas Rd. Suite G
Templeton, CA 93465

PATIENT INFORMATION				
Legal First Name:	Mi:	Last:	Preferred Name:	
Mailing Address:		Zip Code:	City:	State:
Driver's License #:	State:	SSN:	Date of Birth:	Gender: □ M □ F
E-mail Address:	Primary Phone: □ Cell □ Home		Secondary Phone: □ Cell □ Home	
Appointment Reminder Method: □ Text □ E-mail □ Phone	Employer:		Work Phone:	
Primary Physician:		Referring Physician (if different):		
Emergency Contact Name:		Relationship to Patient:	Primary Phone:	

INSURANCE INFORMATION			
Primary Insurance: □ PPO □ HMO □ Other	Member ID:	Group #:	
Primary Subscriber's Name:	SSN:	Date of Birth:	Gender: □ M □ F
Address (if different from patient):		Relationship to Patient:	
Secondary Insurance: □ PPO □ Supplement □ Other	Member ID:	Group #:	
Secondary Subscriber's Name:	SSN:	Date of Birth:	Gender: □ M □ F

I authorize treatment for the patient named above and accept responsibility for the charges incurred for medical services. I understand that it is customary to pay for services at the time they are rendered unless other arrangements are made in advance. I authorize the release of any information contained in my records to my insurance company, if necessary, but unless notified, I am responsible for billing my insurance company. I authorize the release of any information contained in my medical records to another physician's office.

Patient/Guardian Signature **Date**

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Pharmacy Name: _____

Locations: _____

MEDICAL HISTORY AND INTAKE FORM

PATIENT NAME:	DATE:

PAST MEDICAL CONDITIONS: (CIRCLE ALL THAT APPLY)

NONE
ANXIETY DISORDER
ARTHRITIS
ASTHMA
ATRIAL FIBRILLATION (IRREGULAR HEARTBEAT)
BENIGH PROSTATIC HYPRPLACIA
CEREBROVASCULAR ACCIDENT
CRONIC OBSTRUCTIVE LUNG DISEASE
CORONARY ARTERIOSCLEROSIS
DEPRESSIVE DISORDER
DIABETES MELLLITUS
DISEASE CAUSED BY 2019-COVID
ELEVATED BLOOD PRESSURE
END STAGE RENAL DISEASE
EPILEPSY
GASTROESOPHAGEAL REFLUX DISEASE
H/O: HYPERTENSION
HEARING LOSS
HUMAN IMMUNODEFIECENCY VIRUS INFECTION
HYPERCHOLESTEROLEMIA
HYPERTHYROIDISM
HYPOTHYYROIDISM
INFLAMMATORY DISEASE OF LIVER
LEUKEMIA
MALIGNANT LYMPHOMA
MALIGNANT TUMOR OF BREAST
MALIGNANT TUMOR OF COLON
MALIGNANT TUMOR OF LUNG
MALIGNANT TUMOR OF PROSTATE
RADIATION THERAPY TREATMENT MGMT
TRANSPLANTASTION OF BONE MARROW
OTHER: _____

PAST SURGERIES: (CIRCLE ALL THE APPLY)

NONE
ABDOMINOPERINEAL RESECTION
BILATERAL REPLACEMENT OF KNEE JOINTS
BIOPSY OF BREAST
BIOPSY OF PROSTATE
CORONARY ARTERY BYPASS GRAFT
ENTIRE TRANSPLANTED KIDNEY
EXCISION OF BASAL CELL CARCINOMA
EXCISION OF MELANOMA
EXCISION OF SQUAMOUS CELL CARCINOMA
H/O: COLOSTOMY
OPERATIONPROSTATECTOMY
H/O: TUBAL LIGATION
HISTORY OF APPENDECTOMY
HISTORY OF BILATERAL MASTECTOMY
HISTORY OF CHOLECYSTECTOMY
LUMPECTOMY OF BREAST
LUMPECTOMY OF LEFT BREAST
LUMPECTOMY OF RIGHT BREAST
MASTECTOMY OF LEFT BREAST
MASTECTOMY OF RIGHT BREAST
MECHANICAL HEART ALVE REPLACEMENT
OOPHORECTOMY
PANCREATTECTOMY
PERCUTANEOUS EXTRACTION OF KIDNEY STONE WITH FRAGMENTATION PROCEDURE
PORTOSYSTEMIC SHUNT
PROSTHETIC ARTHROPLASY OF BILATERAL
SPLENECTOMY
SURGICAL BIOPSY OF SKIN
TOTAL NEPHRECTOMY

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HISTORY OF COLECTOMY
HISTORY OF LIVER EXCISION
HISTORY OF PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY
HISTORY OF TISSUE GRAFT HEART VALVE REPLACEMENT
HISTORY OF TOTAL CYSTECTOMY
HISTORY OF TRANSURETHRAL PROSTATECTOMY
HYSTERECTOMY
KIDNEY BIOPSY
LOWER ANTERIOR RESECTION OF RECTUM
TOTAL ORCHIDECTOMY
TOTAL REPLACEMENT OF LEFT HIP JOINT
TOTAL REPLACEMENT OF LEFT KNEE JOINT
TOTAL REPLACEMENT OF RIGHT HIP JOINT
TOTAL REPLACEMENT OF RIGHT KNEE JOINT
TRASPLANTATION OF HEART
TRANSPLANT OF LIVER
OTHER

PATIENT NAME:	**DATE:**

SKIN CONDITIONS: (CIRCLE ALL THAT APPLY)

NONE
ACNE
ACTINIC KERATOSES
ASTEATOSIS CUTIS
BASAL CELL SKIN CANCER
CONTACT DERMATITIS DUE TO POISON IVY
DYSPLASTIC NEVUS OF SKIN
H/O: ASTHMA
H/O: HAY FEVER
MALIGNANT MELANOMA
PRURITUS OF SCALP
PSORIASIS
SQUAMOUS CELL CARCINOMA
SUNBURN OF SECOND DEGREE

SKIN PROTECTION

Do you wear sunscreen? **YES / NO** If yes, what SPF? _____

Do you tan in a tanning salon? **YES / NO**

FAMILY HISTORY OF MELANOMA

Do you have a family history of Melanoma? **YES / NO**

If yes, which relative(s)? _____

MEDICATION LIST

List of all current medications *(including over-the-counter meds, vitamins, and herbals)*:					
Name	**Strength/Unit**	**Route** *(i.e., oral, transdermal, intravenous)*	**Dose**	**Dose Form** *(i.e., tablet, liquid, topical)*	**Frequency**

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Note: If you have more than seven medications, please list the remaining on the backside of this page.					

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO

IF YES, PLEASE LIST: _____

_____

Patient/Guardian Signature _____

SOCIAL HISTORY

TOBACCO (CIGARETTE) SMOKING STATUS: (CIRCLE ALL THAT APPLY)

CURRENT EVERYDAY SMOKER
CURRENT SMOKER SOME DAYS
FORMER SMOKER
NEVER SMOKER

SOCIAL HISTORY DETAILS: (CIRCLE ALL THAT APPLY)

ALCOHOL: NONE
ALCOHOL: LESS THAN 1 DRINK PER DAY
ALCOHOL: 1-2 DRINKS PER DAY
ALCOHOL: 3 OR MORE DRINKS PER DAY

MIPS QUESTIONNAIRE

VACCINATION STATUS

Have you received your influenza vaccination? **YES / NO** If no, reason:
_____

Have you received your pneumonia vaccination? **YES / NO** If no, reason:
_____

HEALTHCARE DIRECTIVE

If you are 65 years of age or older do you have an Advanced Care Plan **YES/NO**
If yes, do you have appointed surrogate/proxy? **YES/NO**
If yes, please provide name of proxy: _____

Which statement(s) best reflects your wishes on advanced care recommendations?

Do not intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.
Do not resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.
Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

PATIENT/GAURDIAN SIGNATURE: _____ DATE: _____

FINANCIAL AGREEMENT AND OFFICE POLICIES

Consent to Pay for Services Rendered: Payment is required for all services at the time the services are performed. If we are contracted providers (in-network) with your insurance plan, we are required by contract to collect your copayment/coinsurance and any unmet deductible. It is **your** responsibility to verify if we are a contracted provider and to understand your coverage benefits under your policy.

- Insurance coverage, authorization, and pre-certification are not guarantees of payment by your insurance company. If your insurance fails to respond or does not respond promptly, we will forward the balance to you for payment.
- If we provide services to you that are not covered by your health plan, you will be responsible for payment at the time the services are performed. Should your insurance company pay after you have already paid us, we will promptly refund you.
- We accept check, Visa, MasterCard, Discover, American Express, and Care Credit for your convenience. Aesthetic services are on a cash or credit card service only.

Office Policies: We will call to confirm most appointments at least 24 hours in advance. If you are more than 15 minutes late by our clock, you may be asked to reschedule your appointment. Cancellations must be made 24 hours prior to your appointment. Children under the age of 18 must be accompanied by a parent or guardian. If the parent or guardian is not present, a minor consent form must be signed. Medical records may be viewed online via your patient portal. If you would like access to your patient portal, please see the front desk for more information. Otherwise, a physical copy of your medical records can be requested for a $25 clerical fee.

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We charge $50.00 for missed appointments, including aesthetics.
You may call our main number at (805) 434-2821 to reschedule.

A fee of $200.00 may apply if a 24-hour notice is not given for surgical procedures OR aesthetic procedures scheduled with a physician.
Cancellations for surgical appointments including MOHS surgery must be made 24 hours prior to your appointment.

Cancellations for aesthetic appointments that have been scheduled with a physician must also be made 24 hours prior to your appointment or they may be subject to a fee of $200.

Please read the following specifics regarding our payment and collection processes.

I understand I will be responsible for any remaining balance not covered by my insurance company within 30 days of receiving my statement.

I understand that procedures performed in this office are often separate, billable services that are not included in the office visit. I understand that many insurance companies apply these procedures to a deductible or coinsurance and may not be covered under the copayment. I am responsible for any unmet deductible or coinsurance at the time of service. It is my responsibility to know and understand what my policy benefits are with my insurance company.
I understand that if I have a surgical procedure or biopsy done at Plateroti Dermatology, there are two charges. First is the provider charge for collecting the biopsy. The second charge is to examine the specimen by a pathologist, chosen by my attending physician. I will be billed separately for these pathology charges by the pathologist who does the reading.
I understand that my insurance company may have a preferred laboratory for blood work. It is my responsibility to know which preferred laboratory company I need to use. It is also my responsibility to inform my provider of this at the time services are rendered.
Plateroti Dermatology refers delinquent accounts to Action Professionals collection agency. Once my account is delinquent and sent to collections, I will be dismissed from the practice.
I understand that a $35 returned check fee will be applied to my account for any checks returned by my financial institution. I also understand that payment of the check and fee will be due immediately and I will no longer be able to issue a check as payment to the practice.
I have read the above financial and office policies and agree to meet my financial obligation in accordance with these policies. I hereby authorize any insurance company to pay Dermatology Associates of the North County. A copy of this authorization can be considered an original for insurance purposes.

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

I give permission to release medical information that may include, but not limited to, appointments, prescriptions, and test results to the following designated people. I understand that due to HIPAA guidelines, medical information will only be discussed with me and those listed below.

1._____ Relationship: _____ Ph#:_____

2._____ Relationship: _____ Ph#:_____

3._____ Relationship: _____ Ph#:_____

I give permission to have telephone messages left on answering machine: □ **Yes** □ **No**

I give permission to have mail sent to my home address: □ **Yes** □ **No**

I give permission to leave MESSAGES/CALL BACK NUMBERS at my work: □ **Yes** □ **No**

Work #: _____

I give permission to have my records faxed wherever I choose at my request: □ **Yes** □ **No**
Signature of Patient/Guardian:

_____ Date: _____

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MINOR PATIENT CONSENT

I, _____, from this date forward give permission to Dr. Carmelo Plateroti's office to treat my son/daughter, _____ without the presence of a parent or guardian.

Signature of Guardian: _____Date:_____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under Heath Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____

Patient Name (Print)

_____ _____

Signature of Patient or Guardian **Date**

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FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below.

Date:	**Staff Initials:**	**Reason:**