

**PATIENT INFORMATION**

(Please Print)

Today's Date \_\_\_/\_\_\_/\_\_\_

Name \_\_\_\_\_  
Last First M.I.  
Mailing Address \_\_\_\_\_  
City State Zip  
Home Phone (\_\_\_\_) \_\_\_\_\_ WorkPhone (\_\_\_\_) \_\_\_\_\_ SS# \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

**PARENT OR RESPONSIBLE PARTY (if different from patient)**

Name \_\_\_\_\_  
Last First M.I.  
Address \_\_\_\_\_  
City State Zip  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ SS# \_\_\_\_\_  
Area Code Area Code

**INSURANCE INFORMATION (Please present insurance card at time of check in.)**

Primary Insurance Name \_\_\_\_\_  
Ins. Address \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Sex \_\_\_\_\_  
Insured's ID# \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_  
Group# \_\_\_\_\_  
Employer Name \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Employer Phone (\_\_\_\_) \_\_\_\_\_  
Relationship of patient to the Insured \_\_\_\_\_  
Other family members that are patients \_\_\_\_\_  
Pharmacy of choice \_\_\_\_\_ Phone \_\_\_\_\_  
In case of Emergency, who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_  
Referred by: \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. Coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments for those patients, applicable co-payments and deductibles will be collected. There will be a \$25.00 billing fee added to your account if payment is not collected at time of service. This fee will however be waived if payment is received in our office within forty-eight (48) hours. We accept payment in the form of cash, check, or credit card. In the event that your account must be turned over to collections, a \$25.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Copy of insurance card (both sides) attached.

Updated By: \_\_\_\_\_

**Please check if you have ever had:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Hay fever       | <input type="checkbox"/> Internal Cancer                       |
| <input type="checkbox"/> Skin Cancer  | <input type="checkbox"/> Heart Disease   | <input type="checkbox"/> High Blood Pressure                   |
| <input type="checkbox"/> Lung Disease   | <input type="checkbox"/> Eye Disease     | <input type="checkbox"/> Neurological Disease (e.g., Epilepsy) |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Inherited Diseases                    |
| <input type="checkbox"/> Measles  | <input type="checkbox"/> Mumps           | <input type="checkbox"/> Chicken Pox                           |
| <input type="checkbox"/> Boils  | <input type="checkbox"/> Hepatitis       | <input type="checkbox"/> Colitis/Bowel Problems                |
| <input type="checkbox"/> Herpes (Shingles or Cold Sores)  |  | <input type="checkbox"/> Keloids/Thick Scars                   |
| <input type="checkbox"/> Venereal Disease   |  | <input type="checkbox"/> Dry Flaking/Cracking Skin             |
| <input type="checkbox"/> Recurrent Skin Infection   |  |  |
| <input type="checkbox"/> Autoimmune disorders ( Lupus, Scleroderma, Fibromyalgia, other _____ ) |  |  |
| <input type="checkbox"/> Other Skin Conditions, specify: _____                                  |  |  |

**Please check if you:**

- |   |   |
|---|---|
| <input type="checkbox"/> Bruise easily                          | <input type="checkbox"/> Suffer from recurring diarrhea |
| <input type="checkbox"/> Suffer from heartburn or indigestion   | <input type="checkbox"/> Suffer from headaches          |
| <input type="checkbox"/> Have abnormal or rapid pulse/heartbeat | <input type="checkbox"/> Use a pace-maker heart device  |
| <input type="checkbox"/> Suffer from fainting                   | <input type="checkbox"/> wear contact lenses            |

Other information which you would like to bring to the doctor's attention regarding your medical condition, medical history or your family's medical history: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please put a check mark next to the procedures about which you would like to receive more information:**

- |   |   |
|---|---|
| <input type="checkbox"/> Botox Therapy                      | <input type="checkbox"/> Brown Spots                |
| <input type="checkbox"/> Enhanced Skin Rejuvenation         | <input type="checkbox"/> Sun Damage                 |
| <input type="checkbox"/> Collagen Augmentation              | <input type="checkbox"/> Broken Capillaries         |
| <input type="checkbox"/> Wrinkles                           | <input type="checkbox"/> Spider Veins/Leg Veins     |
| <input type="checkbox"/> Skin Toning or Pore Size Reduction | <input type="checkbox"/> Hair Removal               |
| <input type="checkbox"/> Facial Redness                     | <input type="checkbox"/> Shaving Bumps/Ingrown Hair |

**CONSENT FOR EXAMINATION AND TREATMENT**

I hereby authorize Dr. Cheryl L. Effron to examine the patient named on the Patient Information form and to administer any treatment the doctor deems necessary for the patient. I agree to pay in full for all services at the time of the office visit, unless other arrangements have been agreed upon in advance by the doctor.

\_\_\_\_\_  
Signature of Patient or Patient's Guardian/Parent

\_\_\_\_\_  
Date

## Dermatology Medical History

Patient: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Today's

Date: \_\_\_/\_\_\_/\_\_\_

Reason for today's visit:

Are you allergic to any medications?  YES  NO If yes, list below:

1. \_\_\_\_\_

2. \_\_\_\_\_

Have you ever had dental anesthesia (Novocaine)?  YES  NO Any bad reaction?  YES  NO

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals):

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

<b>Lungs:</b>	YES	NO	<b>Other Systemic:</b>	YES	NO
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst/hunger	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Amputation	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
			Frequency/burning	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cardiovascular:</b>	YES	NO	Gastrointestinal		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Nausea, vomiting, diarrhea		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infection when		
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of vein	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Limited motion	<input type="checkbox"/>	<input type="checkbox"/>
			<b>Artificial joint</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Pacemaker</b>	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
			Fainting	<input type="checkbox"/>	<input type="checkbox"/>

List any other diseases or conditions:

\_\_\_\_\_

List surgical procedures you have had in the last 6 months:

**Skin:** Have you ever had skin cancer?  YES  NO

Has anyone in your family had skin cancer?  YES  NO

Do you have a history of any specific skin diseases?  YES  NO

If yes, \_\_\_\_\_

Do you have problems with healing  YES  NO

Do you develop keloids (scars) after surgery  YES  NO

Do you bleed easily?  YES  NO

Do you develop skin rashes in reaction to:

Medications  Food  Environment  Bandages  Topical Neosporin

Other \_\_\_\_\_

**Social History:**

Do you drink alcohol?  YES  NO If YES \_\_\_\_\_ drinks per day

Do you use IV drugs?  YES  NO If YES, what? \_\_\_\_\_

How often? \_\_\_\_\_

Do you smoke?  YES  NO

If YES, how much: \_\_\_\_\_

Have you had or have you been exposed to HIV (AIDS)?  YES  NO

Please answer the following questions:

**(Women) Are you pregnant?**  YES  NO Due Date: \_\_\_/\_\_\_/\_\_\_

What is your occupation? \_\_\_\_\_

Hobbies? \_\_\_\_\_

Completed by:  Patient

Medical Assistant \_\_\_\_\_

Initials

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signed by Patient Date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Reviewed by Date

# **Cosmetic Dermatology of Orange County, Inc.**

Medical, Surgical & Cosmetic Dermatology

500 South Anaheim Hills Road, Suite 210  
Anaheim Hills, California 92807  
Telephone: (714) 974-3272  
Fax: (714) 974-4517

17822 Beach Blvd., Suite 452  
Huntington Beach, California 92647  
Telephone: (714) 848-5851  
Fax: (714) 848-9801

E-mail: *skindoc@juno.com*

Dear Valued Patient:

As a convenience to our patients we are contracted with certain insurance carriers to bill them for the services rendered for a given date of service. Please take a moment to become aware of our billing department policy.

It is our policy to bill an insurance company on your behalf twice. If the insurance company fails to honor their agreement to pay timely after two submissions, the payment will become the patient's obligation. Any additional billing that is requested after second submission will incur an additional \$25.00 service charge to your account.

If your insurance company fails to pay your claim you will be notified in writing. If you receive a notice, please feel free to contact your insurance company. We will gladly accept their payment on your behalf. Thank you for your patronage.

I have read and understand the above insurance company billing policy.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

# **Cosmetic Dermatology of Orange County, Inc.**

Medical, Surgical & Cosmetic Dermatology

500 South Anaheim Hills Road, Suite 210  
Anaheim Hills, California 92807  
Telephone: (714) 974-3272  
Fax: (714) 974-4517

17822 Beach Blvd., Suite 452  
Huntington Beach, California 92647  
Telephone: (714) 848-5851  
Fax: (714) 848-9801

E-mail: *skindoc@juno.com*

## **BLANKET ASSIGNMENT FORM**

I REQUEST THAT PAYMENT UNDER MY MEDICAL INSURANCE PROGRAM  
BE MADE TO CHERYL L. EFFRON, M.D., INC. ON ANY AND ALL SERVICES  
RENDERED TO ME BY THIS PROVIDER.

---

SIGNATURE

---

PRINT YOUR NAME

---

DATE SIGNED