NEW PATIENT FORM

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PATIENT DEMOGRAPHICS

Prefix:	Patient's First Name:	Preferred Name:	M.I.:	Last Name:

Mailing Address:	Apt:	City:	State:	Zip Code:

Social Security No. (necessary for billing):	Marital Status:	Birth Date: / /	Age:	Sex:

Guardian's Last Name (if patient is a minor):	Guardian's First Name:	Relationship to Patient:	Guardian's Social Security No.:

Please mark the box of your preferred phone contact

☐ Home Phone: ( )	☐ Work Phone: ( )	☐ Cell Phone: ( )
Driver's License No. / State: /	Email address:	Other Family Members Seen Here:
Occupation Status: ☐ Full-Time ☐ Student ☐ Part-Time ☐ Retired ☐ Currently Unemployed ☐ Disabled	Occupation:	Employer:
	Preferred Pharmacy.:	Pharmacy Phone No.: ( )

How did you hear about us?

☐ Referring Physician ☐ Family Member ☐ Friend ☐ Google ☐ Yelp ☐ TV / Magazine ☐ Insurance Plan ☐ Close to Home / Work ☐

Please provide names and/or details when appropriate:

ADDITIONAL DEMOGRAPHICS

These questions are required to comply with new Federal Health guidelines - every patient is asked for this Information

Race (check one):

☐American Indian/Alaskan Native ☐Black/African American ☐Asian
☐White ☐Native Hawaiian/Pacific Islander ☐ Other:_____

Ethnicity (check one) :

☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Preferred Language (check one):

☐English ☐Spanish ☐Other:_____

IN CASE OF EMERGENCY

First Name of Contact:	Last Name of Contact:	Relationship to Patient:
☐ Home Phone: ( )	☐ Work Phone: ( )	☐ Cell Phone: ( )

I ALLOW MY MEDICAL INFORMATION TO BE RELEASED TO:

First Name:	Last Name:	Relationship to Patient:
First Name:	Last Name:	Relationship to Patient:
First Name:	Last Name:	Relationship to Patient:

PRIMARY CARE PHYSICIAN (required for Medicare patients):

First Name:	Last Name:	Contact Number:

DERMATOLOGICAL HISTORY

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Reason for today's visit: _____ Date: _____

Please list any drug **allergies**:

Allergy	Reaction
_____	_____
_____	_____

Please list all prescription & over-the-counter **medications**, vitamins, and herbals that you frequently take:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Do you take any additional pain medications or **blood-thinning** medications, such as Aspirin, Advil, Motrin, Aleve, Excedrin, Ibuprophen, Coumadin, and Plavix? ☐ No ☐ Yes: If yes, please list below.

1. _____ 2. _____ 3. _____

		Type*	Year	Location
Have you ever had skin cancer?	☐ No ☐ Yes:	_____	_____	_____

		Type*	Who
Has a family member had skin cancer?	☐ No ☐ Yes:	_____	_____

* Types of skin cancer: Basal cell carcinoma (BCC), Squamous cell carcinoma (SCC), Melanoma

Do you have a history of any specific skin diseases? ☐ No ☐ Yes: _____

Do you develop keloids (raised scars) after surgery? ☐ No ☐ Yes

Do you bleed easily? ☐ No ☐ Yes

Key Past Medical History (please check all that apply)

- ☐ AIDS/HIV+
- ☐ Arthritis
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Bleeding Tendency
- ☐ Blood Clots
- ☐ Blood/Plasma Transfusions
- ☐ Cancer, type: _____
- ☐ Chickenpox
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Pacemaker
- ☐ Thyroid Disease
- ☐ Yeast Infections on Antibiotics

Current Height: ____ Current Weight: ____ Most Recent Blood Pressure: ____

	Event / Condition	Year
Please list any previous surgeries, serious illnesses, and/or hospitalizations:	_____	_____
	_____	_____

Do you drink alcohol? ☐ No ☐ Yes: _____ drinks per day / week / month (circle)

Do you smoke tobacco? ☐ No ☐ Previously, but quit ☐ Socially ☐ Yes: _____ packs per day

Have you been exposed to HIV (AIDS)? ☐ No ☐ Yes

(Women) Are you pregnant? ☐ No ☐ Yes, Due date: _____

What is your occupation? _____ Hobbies? _____

REVIEW OF SYSTEMS

please check all that apply

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Name: _____ Date: _____

General
- ☐ Fatigue
- ☐ Fever or chills
- ☐ Weakness
- ☐ Night sweats

Nose
- ☐ Stuffiness
- ☐ Discharge
- ☐ Itching
- ☐ Hay fever
- ☐ Nosebleeds

Neck
- ☐ Lumps
- ☐ Swollen glands
- ☐ Pain
- ☐ Stiffness

Throat
- ☐ Dental problems
- ☐ Gums
- ☐ Bleeding
- ☐ Dentures
- ☐ Sore tongue
- ☐ Dry mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Last dental exam: _____
- ☐ Non-healing sores
- ☐ Thrush

Endocrine
- ☐ Unable to tolerate heat or cold
- ☐ Sweating
- ☐ Increased facial hair (females only)
- ☐ Unexpected weight gain or loss
- ☐ Frequent urination
- ☐ Thirst
- ☐ Change in appetite

Psychiatric
- ☐ Anxiety
- ☐ Stress
- ☐ Depression
- ☐ Suicidal or Homicidal thoughts
- ☐ Mood swings
- ☐ Memory loss

Hematologic
- ☐ Ease of bruising
- ☐ Ease of bleeding

Skin
- ☐ Rashes
- ☐ Lumps or Growths
- ☐ Sores
- ☐ Bleeding sites
- ☐ Itching
- ☐ Dryness
- ☐ Color changes
- ☐ Hair changes
- ☐ Nail changes

Respiratory
- ☐ Cough (productive)
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Painful breathing

Cardiovascular
- ☐ Chest pain or discomfort
- ☐ Palpitations (heart racing)
- ☐ Shortness of breath with activity
- ☐ Fainting spells
- ☐ Swelling of legs
- ☐ Leg pain in calf/thigh
- ☐ Aching or Burning in legs
- ☐ High blood pressure

Neurologic
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Repeated headaches
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Tremor
- ☐ Problems with memory or speech

Gastrointestinal
- ☐ Swallowing difficulties
- ☐ Heartburn
- ☐ Change in appetite
- ☐ Nausea / Vomiting
- ☐ Change in bowel habits
- ☐ Rectal bleeding
- ☐ Constipation
- ☐ Diarrhea
- ☐ Yellow eyes or skin

Lymph
- ☐ Swollen glands (armits or groin)

Ears
- ☐ Decreased hearing
- ☐ Ringing in ears
- ☐ Earache
- ☐ Drainage

Eyes
- ☐ Glasses or contacts
- ☐ Pain
- ☐ Redness
- ☐ Blurry or double vision
- ☐ Last eye exam: _____
- ☐ Cataracts
- ☐ Glaucoma

Musculoskeletal
- ☐ Muscle or joint pain
- ☐ Stiffness
- ☐ Limited motion of arms / legs
- ☐ Back pain
- ☐ Redness of joints
- ☐ Swelling of joints
- ☐ Trauma

Breasts (females)
- ☐ Lumps
- ☐ Swollen glands
- ☐ Discharge
- ☐ Breast-feeding

Genital

- Males -

- ☐ Hernia
- ☐ Penile discharge
- ☐ Sores
- ☐ Masses or pain
- ☐ STD's
- ☐ Swelling in scrotum

- Females -

- ☐ Vaginal discharge
- ☐ Itching or Rash
- ☐ STD's
- ☐ Irregular periods
- ☐ ≥ 3 yeast infections in 1 year

Urinary
- ☐ High urination frequency
- ☐ Burning or Pain during urination
- ☐ Blood in urine
- ☐ Incontinence

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AFFIRMATION PAGE

To the Patient:

- Office Documents -

Your signature in the box below indicates that the information you have entered in the documents listed below are true to the best of your knowledge.

- Patient Information
- Dermatology Medical History
- Review of Systems

- Payment Policy -

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 have an insurance plan with which we participate. Applicable co-payments, co-insurances, and deductibles will be collected at the time of your visit. You are financially responsible for all cosmetic procedures; this office does not bill insurance companies for cosmetic procedures that are not medically necessary. We accept payment in the form of cash or credit card. If payment is not made by either you or your insurance within 120 days, all unpaid balances will be turned over to a collection agency. You will be responsible for all collection costs, including court, attorney, collection fees, and interest fees.

- 24 hour CANCELLATION or RESCHEDULE Notice -

Our practice values our patients and specifically reserves an appointment time for you to address your questions and concerns. Because of this, we ask that you notify our office 24 hours in advance to reschedule or cancel your appointment. For appointments that are not cancelled or rescheduled with at least 24 hours advance notice, you may be charged a $30 cancellation fee. We always offer our patients courtesy reminder emails and phone calls, and it is your responsibility to provide our office with a working phone number and email address. As these reminders are a courtesy, you are still responsible for the $30 cancellation or no show fee even if you do not receive a reminder.

Your signature in the box below also signifies your understanding and willingness to comply with the above policy and gives the office of Batra Dermatology authorization to release any information required to process your claims.

- Medicare –

For Medicare patients only, your signature in the box below also authorizes the payment of Medicare benefits to be made on your behalf and gives the office of Batra Dermatology authorization to release any information to CMS required to process your claims.

PLEASE COMPLETE THE INFORMATION BELOW

The Office Documents listed above were completed by:

☐ Patient ☐ Parent / Guardian ☐ Caregiver ☐ Batra staff ☐ Other: _____

This Affirmation Page will be signed by:

☐ Patient ☐ Parent / Guardian ☐ Caregiver ☐ Batra staff ☐ Other: _____

X_____ _____

Signature Date

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ACKNOWLEDGEMENT OF PATIENT PRIVACY

Notice to Patient:

Batra Dermatology is committed to protecting the privacy and security of our patients and all Protected Health Information (PHI). During the course of your treatment, we may be required to share information with other medical providers for the benefit of your care. This is all within the regulations set by the Federal and State laws regarding PHI. Your information is only released with your written consent to do so and can be revoked at any time by you as provided by law. If you have any questions regarding this consent, please feel free to ask our staff members. We can provide you with a copy of our "Notice of Privacy Practices" at your request, which states how we may use and/or disclose your health information.

Please sign this form to acknowledge that you have had your questions regarding our privacy practices answered. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have had the opportunity to request a copy of this office's Notice of Privacy Practices.

_____ X_____

Patient Name Patient Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation, it was not possible to obtain an acknowledgement.
- We were not able to communicate with the patient.
- Other:

X_____ _____

Employee Signature Date

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CREDIT CARD PRE-AUTHORIZATION FORM

In order to simplify the billing process, **EFFECTIVE AS OF SEPTEMBER 1, 2013**, Batra Dermatology will no longer be sending out billing statements for outstanding balances on patient accounts. We ask that you provide our office with pre-authorization to apply any outstanding balances due to us, after your insurance has processed and paid their portion of your claims, to your credit card. This includes, but is not limited to, co-pays, co-insurances, deductibles, non-covered charges, and 24-hour cancellation/no-show fees. A receipt detailing any credit card payments that we process will be sent to your email address on file. This new policy does not change our office policy of collecting your co-pay, co-insurance and deductible at the time of your visits. If your insurance overpays what they have quoted our office at the time of your visit, a refund will be issued to you within 30 days.

I authorize R. Sonia Batra, MD, Inc. to keep my signature on file and to charge my credit card for any portion of a claim that I am responsible for, or is not paid or covered by my insurance carrier, or for fees I am responsible for but have yet to pay.

☐ VISA ☐ MasterCard ☐ AMERICAN EXPRESS

Cardholder Name:_____

Credit Card #:_____

Expiration Date:_____

Security Code: _____

Address associated with the card: _____

_____

_____

Card Holder Signature: _____

Date: _____

This information is filed securely along with your other confidential information

If you elect not to sign this form, we will send you a paper statement for any outstanding balances. If any balances are not paid off in-full within 30 days of the statement date, it will be subject to an interest fee each month it is not paid in full.

Please sign here as acknowledgement of the previous paragraph

Name: _____ Date: _____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services _____

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

TO BE SIGNED IN OFFICE

By: _____ _____

Patient's or Patient Representative's Signature Date

By: _____ _____

Physician's or Authorized Representative's Signature Date

By: _____

Print Patient's Name

_____

Print or Stamp Name of Physician, Medical Group, or Association Name

_____

(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.