PATIENT DATA SHEET

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone:_____ Home Phone: _____ Work:_____

Date of Birth: _____ Social Security: _____

May our office leave a message on your voicemail? Yes No

By providing your email address here _____, you authorize us to email you information such as appointment, reminder, e-statements. We respect your privacy.

Employer Name: _____ Employer Address: _____

Family Physician Name and Address: _____

Emergency Contact Person: _____ Phone: _____

Pharmacy of Choice: _____ City: _____

Payment is required for all services at the time they are rendered unless you are in a prepaid plan which we participate in. For those patients, applicable copayments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. In the event that your account is turned over to collections, any unpaid balance after 90 days, will be will be assessed interest at 1.5 % per month (or 18% per year). A holder of this medical debt contract is prohibited by Section 1785.27 of the CA Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

Your signature below signifies your understanding and willingness to comply with this policy.

Signature:_____ Date:_____

DERMATOLOGY MEDICAL HISTORY

Name:_____ Date of Birth:_____/_____/_____

Are you allergic to any medications? YES NO If yes, what are they: _____
Have you ever had dental anesthesia (Novocaine)? YES NO Any bad reaction? YES NO
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? 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:

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

List any other diseases or conditions, if you feel it is important to know: _____

_____

Lungs:

Bronchitis	YES	NO
Emphysema	YES	NO
Asthma	YES	NO
Chronic Cough	YES	NO
Shortness of Breath	YES	NO
Wheezing	YES	NO
Tuberculosis	YES	NO

Cardiovascular:

Pacemaker	YES	NO
High Blood Pressure	YES	NO
Chest Pain	YES	NO
Heart Attack	YES	NO
Heart Murmur	YES	NO
Irregular Heartbeat	YES	NO
Phlebitis	YES	NO
Blood clots	YES	NO

Other Systemic:

Diabetes	YES	NO
Amputation	YES	NO
Thyroid	YES	NO
Bladder	YES	NO
Kidney	YES	NO
Dialysis	YES	NO
Stomach ulcer	YES	NO
Diarrhea	YES	NO
Arthritis/Joint Deformity	YES	NO
Artificial joint(s)	YES	NO
Seizures	YES	NO
Fainting	YES	NO
Organ Transplantation	YES	NO
Nausea, vomiting, diarrhea when taking antibiotics	YES	NO

Other:_____

Social History:
Do you drink alcohol? YES NO If YES, how many drinks per day _____
Do you use IV drugs? YES NO
Do you smoke? YES NO If YES, what? _____ how much: _____
Have you had or have you been exposed to HIV (AIDS)? YES NO
(Women) Are you pregnant? YES NO Due Date: _____
What is/was your occupation? _____
Are you retired? YES NO

Who referred you to us:' Doctor Colleague Ad Insurance Internet

Signature: _____ Date: _____

Please answer the following questions.

It is mandated by the Federal Government, CMS, and the Affordable Care Act

1) Do you use tobacco products ? YES NO

2) Do you drink more than 2 alcoholic drinks per day ? YES NO

3) Did you get the influenza vaccination ? YES NO

4) Did you get the Pneumonia vaccination ? YES NO

5) Have you received COVID vaccination recently ? YES NO

6) Do you have a living will or advance directive? YES NO

Please list your medications:

Are you on blood thinner, vitamin E, or omega-3 fatty acids YES NO

PATIENT FINANCIAL POLICY & SIGNATURE ON FILE

*** Dr. Oriba does not accept Medi-Cal or Central Coast Alliance.**

RELEASE OF INFORMATION:
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.

Signature: _____ Date:_____

PAYMENT POLICY:
MEDICARE PATIENTS: We are participating providers of the Medicare program. We will accept assignments on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% co-payment, We do file with secondary/supplemental carriers. However, in the event that the secondary does not *pay* within 60 days, patients will be billed for the balance. NOTE: If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers.

MEDICARE PATIENTS ONLY:
This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:
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 or carrier any information needed for this or related Medicare Claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment, Regulations pertaining to Medicare assignment of benefits apply.

Signature: _____**Date**: _____

If you have a supplemental policy and it is a MEDIGAP (Medicare Supplement Insurance) policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file.
I request authorized MEDIGAP benefits be *made* on my behalf for any services furnished to me, I authorize any holder of my information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services..

Signature: _____ **Date:** _____

PRIVATE INSURANCE PATIENTS:
You will be responsible for paying your annual deductible, co-payment and charges for any non-covered cosmetic services.

NOTE: Patients who are covered by private, commercial plans in which our physicians are NOT providers will be required to pay 50% of the total bill at the time of service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Signature: _____ Date: _____

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, _____ have reviewed the Notice of Privacy Practices. If I desire a copy, one is available for me.

Signature:_____Date:_____

CURRENT PROBLEM QUESTIONNAIRE

Skin problem being seen for today (rash, growths, warts, etc.): _____
_____
Duration of the skin problem (when first noticed):_____
Treatment: _____
Please mark on the figure where your present skin problem is located.