comprehensive dermatology
OF LONG BEACH

REGISTRATION/CONSENT FORM

(PLEASE PRINT)

Today's Date:

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep /		
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ☐ M ☐ F
Home phone :	Cell Phone:	IF WE NEED TO CONTACT YOU: OK to leave detailed voicemail ☐ Leave call back # only ☐		
Street address/ P.O. Box:	City:	State:	ZIP Code:	
Occupation:	Employer:			
Email Address:	Consent to communicate via Email ☐ Yes ☐ No			
Person(s) we are authorized to release medical results to (if any):				
How were you referred to our office? ☐ Current Patient _____ ☐ Internet ☐ Yelp ☐ Physician _____				
Primary Care Physician:	Phone No. ( )			
Referring Physician:	Phone No. ( )			
Spouse's or Parent's Last Name: First:				
Spouse's or Parent's Phone No. ( )	Birth date: / /			

INSURANCE INFORMATION

Please give your insurance card and photo ID to the receptionist. You must notify us if this is an accident or work related visit.

Subscriber's name:	Subscriber's Birth date: / /
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship to patient:	Cell phone no.: ( )	Additional phone no.: ( )

Office use: Date updated: / / Initials: _____ Reviewed: _____

Date Updated: / / Initials: _____ Reviewed: _____

Date Updated: / / Initials: _____ Reviewed: _____

Date Updated: / / Initials: _____ Reviewed: _____

Don't forget to fill out the reverse side

AUTHORIZATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION:
All professional services rendered are charged to the patient; necessary forms will be completed to expedite insurance carrier payments the patient is responsible for all fees regardless of insurance coverage. All services provided to you as a patient of Comprehensive Dermatology of Long Beach, PC are payable at the time of service and are the sole responsibility of you "the patient" and/or guarantor of "your children". I hereby authorize Comprehensive Dermatology of Long Beach, PC to furnish insurance companies or their representative's information concerning my/my dependents illness and treatments and I hereby assign to Comprehensive Dermatology of Long Beach, PC all payments for medical services rendered by myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I hereby authorize and release the doctor and whomever he/she may designate as his/her assistant to administer treatment, physical exam, x-ray studios, laboratory procedures, medical care or any clinical service that he/she deems necessary in my case, and I further authorize him/her to disclose all or part of my (patients) record to any person or corporation which is or may be liable under contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic charge, including but not limited to hospital or medical services company, insurance company, workers compensation carries, welfare funds, or the patients employer.

PATIENT INFORMATION CONSENT:
I understand that Comprehensive Dermatology of Long Beach, PC may need to use and disclose information about my health or medical problems for the purpose of arranging, conducting, or referring my treatment; for obtaining payment for services and for the purpose of operating the practice. I consent to the use of my information for the purpose of treatment, payment, and health care operations.

I understand that my consent is not needed if the law requires Comprehensive Dermatology of Long Beach, PC to report some aspect of my protected health information to a government agency (for example suspected abuse, communicable disease, and potential bodily harm to myself or others).

I understand that I have the right to review Comprehensive Dermatology of Long Beach, PC privacy notice, to request restrictions be put on the use of my information, and to revoke my consent at a later date.

I understand that if I withhold consent for the use of my information for the purpose of treatment, payment or operations, Comprehensive Dermatology of Long Beach, PC may refuse to undertake my care.

I, the undersigned, hereby consent to the following treatment: administration an performance of all treatments administration of any needed anesthetics, performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, use of prescribed medication, performance of diagnostic procedures/tests, cultures, biopsies, and surgery, performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees. I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. I understand that Comprehensive Dermatology of Long Beach, PC may include consent at satellite offices under common ownership.

MEDICARE PATIENTS:
I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Comprehensive Dermatology of Long Beach, PC.

HIPAA ACKNOWLEDGEMENT:
I have received and have read Comprehensive Dermatology of Long Beach, PC Notices of Privacy Practices.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its content. Also that all information provided above is true and correct to my knowledge.

_____ _____

Patient/Guardian Signature Date