NEWPORT SKIN CANCER

ADAM M. ROTUNDA, M.D. AND KELLY M. BICKLE, M.D.

MOHS MICROGRAPHIC & DERMATOLOGIC SURGERY

Name: _____
Last *First* *M.I.*

Address: _____
Street *City* *State* *Zip*

Telephone: (____)_____(____)_____(____)_____
Home *Mobile* *Work* *ext*

Responsible Party: ☐ **Self** ☐ **Other:**_____ **Relationship:** _____
(i.e., who pays bill for any patient portion)

Primary Care Physician: _____ **Telephone:** (____)_____

Date of Birth: _____ **Sex:** ☐ M ☐ F **Ethnicity:** _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Legally Separated**

Social Security Number: _____

Emergency Contact Name: _____ **Relationship:** _____

Emergency Contact Telephone: _____

Patient Email Address (if you have one): _____

Pharmacy Name & Location: _____ **Pharmacy telephone:** _____

EMPLOYMENT STATUS: ☐ **Full Time** ☐ **Part-Time** ☐ **Self-Employed** ☐ **Retired** ☐ **Not employed** ☐ **Student**

Employer Name: _____

Employer Address: _____
Street *City* *State* *Zip*

INSURANCE INFORMATION

Please check one:
☐ **Self Pay** *(no insurance)* ☐ **Patient IS the policy holder** ☐ **Patient IS NOT the policy holder** *(fill out below)*

If the above named patient is not the primary policy holder, please fill out the following:
INSURED INFORMATION

Name: _____
Last *First* *M.I.*

Date of Birth: _____ **Social Security Number:** _____ **Sex:** ☐ M ☐ F

Address: _____
Street *City* *State* *Zip*

Telephone:(____)_____(____)_____(____)_____
Home *Mobile* *Work* *ext*

Patient's Relationship to insured (i.e. child, spouse, etc.): _____

We are privileged to have you at our practice, who can we thank for referring you to us?

☐ Physician (Dr. _____) ☐ Family/Friend (Name:_____)

1100 QUAIL ST • SUITE 102 • NEWPORT BEACH, CA 92660
O 949-336-7171 • F 949-336-7172 • AR CELL 310-902-5513 • KB CELL 310-998-7230
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Date of Birth: _____/_____/_____

Age: _____

Why are you seeing the doctor today?
What prior treatments have you used for this condition?
What part(s) of your body is (are) affected?
How long have you had the problem?

Past Personal Skin Problems:

- ☐ Abnormal moles
- ☐ Melanoma
- ☐ Skin cancer (type): _____
- ☐ Connective tissue disease
- ☐ Thick scars or keloids
- ☐ Other - specify:

Family History of Skin Problems:

- ☐ Melanoma
- ☐ Skin cancer (other)-specify type
- ☐ Eczema or dermatitis
- ☐ Other - specify:

Allergies and Intolerances (if none, check here ☐) :

Current Medications (including non-prescription and vitamins):

Do you have to take antibiotics before routine dental procedures: ☐ Yes ☐ No

Do you have:

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial heart valve
- ☐ Artificial joints
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Cancer: _____
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ HIV infection/AIDS
- ☐ Kidney disease
- ☐ Liver disease
- ☐ **Pacemaker or Defibrillator**
- ☐ Pneumonia
- ☐ Stomach Ulcer
- ☐ Sores in the mouth
- ☐ Stroke
- ☐ Thyroid problems
- ☐ **CLL (Chronic Leukemia)**
- ☐ **Organ Transplant (organ: _____)**

☐ **OTHER (ie. significant surgeries or other medical illnesses):**

☐ **None of the above**

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What are your **Hobbies**? _____

Habits :

Alcohol: ☐ No ☐ Yes (Amount per week): _____
Tobacco: ☐ No ☐ Yes (Amount per week): _____

Women Only

☐ Postmenopausal

Are you pregnant?	☐ Yes	☐ No
Are you trying to become pregnant?	☐ Yes	☐ No
Are your menstrual periods regular?	☐ Yes	☐ No

Birth control method: _____

Consent and Authorization for Treatment

By my signature below, I authorize evaluation and treatment by Adam M. Rotunda, M.D or Kelly M. Bickle, M.D., which may require them to perform certain laboratory or pathology tests in order to understand and treat my condition. I understand that dermatology is an inexact science and many conditions are chronic and require ongoing care. All medications, if prescribed, have potential side effects and there are risks to any medication prescribed. Dermatologists frequently treat skin growths or lesions by freezing, cauterization, biopsy or excisional biopsy by cutting the lesion out, and/or cortisone injections. I understand that there are risks to any procedure performed on the skin and that these risks include, but are not limited to: permanent discoloration (including lightening/darkening/redness), scarring (including thinning and thickening of the skin), pain, infection, bleeding and nerve damage. These are general risks and vary according to the procedure performed, which will be discussed with me prior to the specific procedure. I consent to any of these procedures as part of my treatment. This authorization and consent shall remain in force for all future visits at Newport Skin Cancer.

Patient Signature: _____ **Date:** _____

Physician Signature: _____

Privacy Practice Acknowledgement (HIPAA)

A copy of this notice is available to you. Please ask the reception staff if you would like one. By signing below, I acknowledge that I have been offered a copy of our Notice of Privacy Practices. By signing below, I authorize Adam M. Rotunda and/or Kelly M. Bickle, M.D. and staff members to leave a detailed message in reference to any items that assist the practice in carrying out healthcare operations. If you *do not* wish to be contacted at a specific location, please indicate below:

Home Phone: ☐ **Do not contact me here** **Mobile Phone:** ☐ **Do not contact me here**

Work Phone: ☐ **Do not contact me here** **E-mail:** ☐ **Do not contact me here**

Please list any persons to whom your protected health information can be disclosed (e.g., spouse, parent, etc.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Release of Medical Information

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and to process insurance claims, insurance applications, prescriptions, or to complete any other medical operations as necessary.

Signature: _____ **Date:**_____/_____/_____

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