COASTAL HILLS
DERMATOLOGY

Lucas Bingham, M.D., Inc.

SIGNATURE PAGE for _____

(Patient Name)

Release of Medical Information

I authorize the release of medical information to my primary care physician and to his/her consultants if needed, and to process insurance claims, insurance applications, or to complete any other medical operations as necessary. I additionally authorize the sharing of medical information between Med-X Healthcare, Inc. and Dr. Bingham MD, Inc. as necessary for my care.

Signature: _____ *Date:* _____

Financial Policy – All Patients, Including Medicare

Payment is required for all services at the time they are rendered unless you are have set a prepaid plan in which we participate. For those patients, applicable co-payments, co-insurance and deductibles will be collected. All medical procedures performed have separate fees in addition to an office visit fee. Our office **does not** accept Cal-Optima/Medi-Cal/Medicaid, most HMO plans, any workers' compensation cases, some PPO insurance plans, and may not accept other plans. Patients are responsible to check our participation with their plan before their visit. The patient is responsible for any and all charges not paid for by their insurance company. If you must cancel or reschedule an appointment, please do so at least 24 hours before the scheduled appointment time. A charge of $50 may be applied to patients who miss their appointment or do not notify the office of a cancellation 24 hours in advance.

I have read and understand the financial policy statement. I agree to make in-full prompt payment when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered. Furthermore, I authorize payment directly to Medx Health Care for medical insurance benefits payable to me under the terms of my policy. This authorization is valid until revoked in writing. ***The SIGNER must complete THEIR OWN information here:***

Financial Policy – Medicare Patients Only

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare, or its intermediaries of carrier, any information needed for this or a related Medicare claim. I permit a copy of their authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. This authorization is valid until revoked in writing.

Signature: _____ *Date:*_____

Privacy Practices (HIPAA)

Notice of Privacy Practices

- 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 MedX 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**	**Work Phone:**	**Do not contact me here**
Mobile Phone:	**Do not contact me here**	**Email:**	**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: _____

Signature: _____ *Date:* _____

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PATIENT INFORMATION

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

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

Home Phone: (_____)_____(_____) _____(_____)_____
Home *Mobile* *Work* *ext*

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

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

Patient Race: ☐ White ☐ Hispanic ☐ Asian ☐ Black or African American
☐ Native Hawaiian ☐ Pacific Islander ☐ Other Race

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Preferred Language**: ☐ English ☐ Spanish ☐ Other: _____
EMPLOYMENT STATUS: ☐ Full Time ☐ Part-Time ☐ Self-Employed ☐ Retired
Employer Name: _____
Employer Address: _____
Street *City* *State* *Zip*
Primary Care Physician: _____**Telephone**: (____)_____

How did you find us?

☐ Physician (Name : _____) ☐ Family or Friend (Name : _____)

☐ Yellow Pages ☐ Insurance Book ☐ Internet ☐ Newspaper Ad ☐ Other: _____

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

Emergency Contact Home Phone: (____)_____ **Emergency Contact Work Phone:** (____)_____

Patient E-mail Address:_____

Pharmacy Name & *LOCATION*: _____**Pharmacy Telephone:**_____

☐ ***I authorize Lucas Bingham, MD, Inc. to review my external medications history***

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: _____

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

COASTAL HILLS DERMATOLOGY

Lucas Bingham, M.D., Inc.

MEDICAL QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Reason for Visit: _____

Do you have or have had any of the following? *(if yes, please check)*

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Artificial heart valve
- ☐ Artificial Joints or metal implant
- ☐ Atopic Dermatitis
- ☐ Atrial Fibrillation
- ☐ Atypical moles
- ☐ Auto immune disease (lupus, rheumatoid arthritis)
- ☐ Bleeding disorder
- ☐ Blood clots
- ☐ Chronic Fatigue or Fibromyalgia
- ☐ Cold sores / herpes
- ☐ Depression
- ☐ Diabetes
- ☐ Down's Syndrome
- ☐ Heartburn / Ulcers/ Gastritis / Reflux
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV
- ☐ Keloids or scarring problems
- ☐ Kidney disease
- ☐ Liver disease or hepatitis
- ☐ Lung disease
- ☐ Melanoma
- ☐ Migraines
- ☐ Multiple sclerosis
- ☐ pacemaker
- ☐ Psoriasis
- ☐ Reactions to local anesthesia
- ☐ Seasonal allergies / asthma
- ☐ Seizures
- ☐ Stroke
- ☐ Skin cancer (basal or squamous cell carcinoma)
- ☐ Cancer, other
  Please list:
- ☐ Thyroid trouble
- ☐ Other conditions
  Please list:

Please list any medications, herbal supplements, and/or vitamins you are currently taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you allergic to any medications? Yes No *(if yes, please list medication and reaction)*

Medication: _____Reaction:_____Medication:_____Reaction:_____

Medication: _____Reaction:_____Medication:_____Reaction:_____

Please list major surgeries:

_____Date: _____ _____Date:_____

_____Date:_____ _____Date:_____

_____Date:_____ _____Date:_____

Please list major hospitalizations:

_____Date:_____ _____Date:_____

_____Date:_____ _____Date:_____

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Please list any relatives (mother, father, grandmother, grandfather, brother, sister) **that have had any of the following conditions:**

- ☐ Skin cancer: _____
- ☐ Eczema: _____
- ☐ Melanoma: _____
- ☐ Diabetes: _____
- ☐ Elevated Cholesterol: _____
- ☐ Seasonal Allergies: _____
- ☐ Psoriasis: _____
- ☐ Autoimmune Disease: _____
- ☐ Cancer: _____
- ☐ Other:_____

How many do you have of the following? Brothers: _____ Sisters: _____ Sons: _____ Daughters: _____

Do you take Coumadin or other blood thinners:	Yes	No
Do you take Aspirin daily?	Yes	No
Do you need antibiotics before surgery or dental work?	Yes	No
Are you pregnant or nursing?	Yes	No
Are you allergic to any local anesthetic?	Yes	No
Do you exercise?	Yes	No
Do you drink alcoholic beverages?	Yes	No
If so, how much (number of beverages / week)?	_____	

What is your occupation? _____

Tobacco Use *(please check one category)*

- ☐ Never a smoker
- ☐ Former smoker. If yes, how long has it been since you last smoked?
  - ○ <1 month 1-3 months 3-6 months 6-12 months 1-5 years 5-10 years >10 years
- ☐ Current smoker. If yes:

  How often do you smoke cigarettes? *(Please check one)*
  - ○ Every day ○ Some days, but not every day

  How many cigarettes a day do you smoke? *(Please check one)*
  - ○ 5 or less ○ 6-10 ○ 11-20 ○ 21-30 ○ 31 or more

  How soon after you wake up do you smoke your first cigarette?
  - ○ Within 5 minutes ○ 6-30 ○ 31-60 ○ after 60 minutes

  Are you interested in quitting? *(Please check one)*
  - ○ Ready to quit ○ Thinking about quitting ○ Not ready to quit

Have you recently had any of the following? *(Please check all that apply)*

- ☐ Weight change
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Headache
- ☐ Vision changes
- ☐ Ringing in ears
- ☐ Recurrent nosebleeds
- ☐ Neck stiffness
- ☐ Enlarged glands
- ☐ Sore throat
- ☐ Chest pain
- ☐ Palpitations
- ☐ Leg swelling
- ☐ Shortness of breath
- ☐ Cough
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in urine
- ☐ Joint pain
- ☐ Muscle aches
- ☐ Heat / Cold intolerance
- ☐ Change in hair pattern
- ☐ Easy bruising
- ☐ Abnormal bleeding
- ☐ Seizures
- ☐ Irregular menstrual cycles
- ☐ Depression
- ☐ Nervousness