Dr. Lucas Bingham, M.D., Inc.
600 Corporate Drive Suite 100
Ladera Ranch, CA 92694
(949) 388-8022 Office
(949) 388-8033 fax

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**: ___________________

Patient E-mail Address:____

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 ☐ Internet ☐ Newspaper Ad ☐ Other: ________________

Emergency Contact Name: ____**Relationship:** ______________________

Emergency Contact Home Phone: (____) ________________ **Emergency Contact Work Phone:** (____)_____________

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*

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MEDICAL QUESTIONNAIRE

Patient Name: ____ **Date:** __________________________

Reason for Visit: ____

Patient Height: ________________________ **Patient Weight:** __________________________

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
- ☐ Downs 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**

Medication: ________________Reaction:_________________Medication:_______________Reaction:____________________

Please list major surgeries:

____________________________Date: ______________ ____________________________Date:___________

____________________________Date:_______________ ____________________________Date:___________

Please list major hospitalization:

____________________________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: ____	☐ Seasonal Allergies: ____
☐ Eczema: ____	☐ Psoriasis: ____
☐ Melanoma: ____	☐ Autoimmune Disease: ____
☐ Diabetes: ____	☐ Cancer: ____
☐ Elevated: ____	☐ 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 per week)	________________	

What is your occupation? ____

Tobacco Use (Please check one category)

☐ Never a smoker

☐ Former smoke, 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

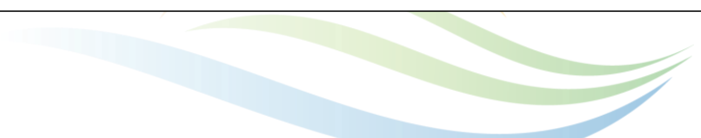
If yes, how often do you smoke cigarettes? ○ Every day ○ Some days, but not every day

How many cigarettes a day do you smoke? ○ 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

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

☐ Weight Change	☐ Neck Stiffness	☐ Nausea	☐ Change in hair pattern	☐ Fever
☐ Enlarged Glands	☐ Vomiting	☐ Easy Bruising	☐ Chills	☐ Sore Throat
☐ Diarrhea	☐ Abnormal Bleeding	☐ Fatigue	☐ Chest Pain	☐ Headache
☐ Constipation	☐ Seizures	☐ Vision Changes	☐ Palpitations	☐ Blood in urine
☐ Irregular Menstrual Cycle	☐ Ringing in ears	☐ Leg Swelling	☐ Joint Pain	☐ Depression
☐ Recurrent Nosebleeds	☐ Shortness of breath	☐ Muscle Aches	☐ Nervousness	☐ Cough
☐ Heat / Cold Intolerance				



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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 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 - $100 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 Coastal Hills Dermatology 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 Dr. Bingham 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: ____

Signature: ____ *Date:* ________________________________

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CoastalHillsDermatology.com

CANCELLATION - NO SHOW – LATE ARRIVAL POLICY

Dear Patient,

Thank you for trusting your medical care with Dr. Lucas Bingham and Coastal Hills Dermatology. We strive to render excellent service to you, your family and all of our patients. In order for us to be consistent with this philosophy, Coastal Hills Dermatology uses an appointment system that sets aside ample time for each patient dependent on the patient's current needs.

If you are unable to make your appointment, or notify us of your inability to keep your appointment by phone at least 24 hours in advance of your appointed time, that time which was allotted for you is not available for us to treat another patient in your place. We understand emergencies happen and will be more than happy to waive any associated fees on a case by case basis.

Our Policy is as follows:

1. We request that you please give our office 24 hour notice in the event that you need to reschedule or cancel your appointment.
2. **If you do not arrive for your appointment as scheduled and have not contacted our office within the 24 hour notification period, we will consider this to be a missed appointment and a fee ranging from $50 to $100, depending on the time allotted for your appointment, will be assessed to you.**
3. If you are late arriving for your appointment, we will make every effort to see you as soon as our schedule allows, though your appointment time may be shortened or we may need to reschedule your appointment.
4. As a courtesy, we have an automated service that provides you with reminder calls of your appointment. Should the automated service not reach you for any reason, you are still responsible for the appointment and the cancellation policy will still remain in effect.

If you have any questions regarding this policy, please contact our office manager at (949) 388-8022 and we will be glad to address them with you.

We sincerely thank you for being our patient and have as our goal to provide you with superior care.

I have read and understand the cancellation policy for Dr. Lucas Bingham and Coastal Hills Dermatology and agree to be bound by these terms.

____________________________________ ____________________________

Patient or Legal Guardian Signature **Relationship to Patient**

____

Printed Name and Date Signed