SONOMA SKIN DERMATOLOGY

181 Andrieux Street, Ste. 103
Sonoma, CA 95476
Office (707) 938-9880, option 3
Fax (707) 938-9879

PATIENT INFORMATION

Name:_____ Date of Birth:_____ Age: _____ Gender: ☐ Male ☐ Female

SSN:_____

Address: _____

Home Phone:_____ Mobile Phone:_____ Work Phone: _____
Email: _____

Preferred Contact: ☐ Home ☐ Mobile ☐ Work ☐ Email

Messages may be left on my voicemail or answering machine regarding appointments, health information, or test results: ☐ Yes ☐ No

Primary Care Physician: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____ Relationship:_____

Address: _____ Emergency Contact Phone: _____

Advance Directive? ☐ Yes ☐ No

DO YOU GIVE OUR OFFICE PERMISSION TO DISCUSS YOUR MEDICAL INFORMATION WITH FAMILY MEMBERS?

☐ Yes ☐ No If yes, please provide their names and contact information below

Name: _____ Relationship:_____

Home Phone: _____ Mobile Phone: _____

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. Knuttel will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

_____ _____

Patient or Responsible Party Signature Date

Sonoma Skin Dermatology

Name: _____ Nickname: _____

***Height: _____ Weight**: _____ **lbs** * **Eye Color:** ☐ blue ☐ brown ☐ hazel ☐ green
***Skin Type:** ☐ white-never tans ☐ fair-tans minimally ☐ light- tans ☐ light brown-tans easily
☐ medium brown-tans profusely ☐ black

MEDICAL HISTORY

- ☐ acne
- ☐ AIDs/HIV disease
- ☐ anemia
- ☐ allergy to local anesthesia
- ☐ arthritis
- ☐ artificial heart valve
- ☐ asthma
- ☐ autoimmune disorder
- ☐ history of blood clot
- ☐ cancer: _____
- ☐ cold sores
- ☐ dementia
- ☐ depression
- ☐ diabetes
- ☐ eczema
- ☐ hay fever
- ☐ heart disease
- ☐ high blood pressure
- ☐ high cholesterol
- ☐ immunodeficiency
- ☐ hepatitis
- ☐ inflammatory bowel disease
- ☐ keloid scarring
- ☐ kidney disease
- ☐ liver disease
- ☐ MRSA
- ☐ multiple sclerosis
- ☐ pacemaker
- ☐ polycystic ovarian syndrome
- ☐ psoriasis
- ☐ stroke
- ☐ shingles vaccine When:_____
- ☐ thyroid disease
- ☐ tuberculosis
- ☐ transfusions
- ☐ vitiligo
- ☐ Other:_____

SURGERIES IN THE PAST 5 YEARS? ☐ NONE

	Date	Surgery	Notes
1			
2			
3			

SKIN CANCER HISTORY

- ☐ actinic keratosis (pre-cancers)
- ☐ melanoma
- ☐ basal cell carcinoma
- ☐ squamous cell carcinoma
- ☐ family history of melanoma

	Date	Type	Location	Treatment
1				
2				
3				

Do you wear sunscreen? ☐ Y ☐ N SPF: _____
Frequency: ☐ daily ☐ rarely ☐ when outdoors for prolonged periods
Do you wear? Hat: ☐ Y ☐ N Sunglasses: ☐ Y ☐ N Protective Clothing: ☐ Y ☐ N
Have you ever used a tanning bed? ☐ Y ☐ N

PERSONAL HISTORY

Alcohol Use:
☐ Never drink alcohol
☐ Occasionally drink alcohol
☐ Drink alcohol daily

Tobacco Use:
☐ Never smoked
☐ Former smoker
☐ Currently smokes

Recreational Drugs: ☐ Y ☐ N If yes, describe: _____

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Name: _____ Nickname: _____

***Female Patients**: ☐ Menopausal ☐ Postmenopausal ☐ Pregnant
☐ Trying to get pregnant ☐ Breast Feeding ☐ Recent baby

SOCIAL HISTORY

Marital Status: ☐Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner
Children: ☐ Y ☐ N
Occupation: _____

CURRENT MEDICATIONS

(include all including vitamins, minerals, hormones and topical therapies)

	Drug	BLOOD THINNERS- Check all that apply
1		☐ Aspirin
2		☐ Ibuprofen (Advil, Motrin)
3		☐ Aleve (Naproxen)
4		☐ Fish Oil
5		☐ Warfarin/Coumadin
6		☐ Plavix (Clopidrogel)
7		☐ Ginkgo
8		☐ Ginseng
9		☐ Xarelto
10		☐ Other:

DRUG ALLERGIES

(including latex, local anesthesia, topical medication)

	Date	Drug	Reaction
1			
2			
3			

PHARMACY

What pharmacy do you use? _____ City: _____

I certify that the above information is accurate and complete to the best of my knowledge.

_____ Date: _____
Patient Signature/Patient Representative Signature

I certify that I have reviewed the above information.

_____Date: _____
Physician Signature

SONOMA SKIN FINANCIAL POLICIES AGREEMENT

Patient Name: _____

Date of Birth: _____

PLEASE READ AND SIGN BELOW

FEES: Our medical and surgical fees are based on the Medicare Fee Schedule for Sonoma County and are reviewed yearly. The fee associated with your visit is based on the complexity and duration of your consultation with the MD and for services rendered. There is typically a fee for each visit and/or service rendered. Fees for visits and services rendered are not refundable. **SURGERY FEES:** All co-pays, deductibles, and payments for non-covered surgical procedures are due prior to your procedure. Prior authorization may be required by your carrier. **NONCOVERED SERVICES:** Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial. Periodic preventive health checks **may or may not be covered** under **your** health insurance policy.

FOR PATIENTS WITH INSURANCE: We accept Medicare, Medicare Supplementals, CIGNA PPO and Meritage Medical Network HMO group. Our contract with these insurance companies requires that your co-pay be paid by you. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than you anticipated for care. **If an insurance carrier has not paid within 90 days of billing, professional fees are due and payable in full from you.**

FOR PATIENTS WITHOUT INSURANCE OR PLANS WE DO NOT ACCEPT OR FOR COSMETIC SERVICES: Payment for service is due in full at the time service is provided in our office. Ask for an estimate of services before they are provided to you.

MISSED APPOINTMENTS: We require at least 48 hours notice to cancel appointments. You **will be charged $50 for missed medical appointments** and **$125 for a missed surgery, cosmetic or laser appointment**.

PAST DUE ACCOUNTS: If we do not receive your payment within 2 billing cycles, your account will be referred to an outside billing & collections agency.

For MEDICARE PATIENTS: We will bill Medicare for you. All copayments or deductibles are due and payable at the time service is provided. Medicare will bill your secondary insurance after processing your claim. Please note you will be responsible for the remaining balance after insurance reimbursement.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Sonoma Skin Dermatology. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

MEDICARE PATIENTS: SIGNATURE ON FILE: I request payment of authorized Medicare benefits be made either to me or on my behalf to Sonoma Skin Dermatology for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature authorizes that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and **the patient is responsible only for the deductible, coinsurance, and non covered services**. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

I have read, understood, and agreed to the above policies. I understand that I am ultimately responsible for all fees.

_____ _____

Patient Signature/Patient Representative Signature **Date**