GROSSMONT DERMATOLOGY MEDICAL CLINIC
GROSSMONT SKIN CANCER TREATMENT CENTER

CONFIDENTIAL PATIENT INFORMATION
PLEASE PRINT LEGIBLY

Name _____ _____ _____ ☐M ☐S ☐D ☐W ☐M ☐F
LAST FIRST MIDDLE MARITAL STATUS SEX

Date of Birth _____ **Social Security No.** _____ **Age** _____

Street Address _____ **Apt. #** _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Race (please circle)
White Black/African American Asian
American Indian or Native Alaskan Native Hawaiian/Pacific Islander

Ethnicity
Hispanic/Latino
Non-Hispanic/Latino

***emails are not encrypted:**
Email _____

Preferred Language: _____ **Do you want marketing information? Circle: Yes or No**

Name of Spouse _____ **or Parent** (IF PATIENT IS A MINOR) _____ _____ _____
NAME NAME RELATION TO PATIENT EMPLOYER

Address (IF DIFFERENT) _____
NUMBER STREET APT # CITY STATE ZIP

Patient's Employer _____
(INDICATE IF STUDENT) ☐ FULL TIME ☐ PART TIME ADDRESS

Nearest Friend or Relative _____
(NOT LIVING IN SAME HOUSEHOLD) NAME RELATIONSHIP TELEPHONE NO.

How did you hear about our office?
☐ Friend or Relative, _____
☐ Advertisement. Where? _____
☐ Internet. Which Website? _____
☐ Phone Book ☐ Provider Booklet ☐ Other _____

☐ May we acknowledge the person who referred you with a thank you note?
☐ Are you a former patient of Dr. Eisman? yes no
☐ Another Doctor. Who? _____

INSURANCE INFORMATION
We will photocopy your card - Please fill in the insurance information.

PRIMARY INSURANCE		SECONDARY INSURANCE	
NAME OF INSURANCE COMPANY		NAME OF INSURANCE COMPANY	
NAME OF POLICYHOLDER	RELATION TO PT.	NAME OF POLICYHOLDER	RELATION TO PT.
POLICYHOLDER D.O.B.	POLICYHOLDER SS.#	POLICYHOLDER D.O.B.	POLICYHOLDER SS.#
POLICYHOLDER EMPLOYER		POLICYHOLDER EMPLOYER	

MEDICAL INFORMATION

Family Doctor _____

Present Skin Problem: _____ Past Treatment: _____

Date Problem Began: _____ Area Involved: _____ Present Treatment: _____

Have you noticed any moles enlarging or changing color? ☐ Yes ☐ No

Would you like to have an overall skin exam for skin cancer today? ☐ Yes ☐ No (No additional fee)

HAVE YOU EVER HAD?	Yes	No		Yes	No		Yes	No		Yes	No
Allergies to Medications (please list)	☐	☐	Diabetes	☐	☐	Kidney Disease	☐	☐	Hepatitis	☐	☐
_____			Cancer	☐	☐	Rheumatic/Collagen Disease	☐	☐	Are you pregnant?	☐	☐
_____			Heart Disease	☐	☐				Are you breast feeding?	☐	☐
_____			Thyroid Condition	☐	☐	Arthritis	☐	☐	High Blood Pressure	☐	☐
						Mental Illness	☐	☐	Other	☐	☐

List all medications taken or creams used during the past two weeks - include aspirin, vitamins, birth control pills, laxatives, insulin, cold pills, etc.

_____

_____

Please list all other medical problems **NOT** mentioned above: _____

_____

Please Turn Over for Signature Page ➡➡➡

I hereby authorize GROSSMONT DERMATOLOGY MEDICAL CLINIC to furnish to my insurance company or to a designated attorney, all information which the insurance or attorney may request. I hereby assign to the above-referenced physicians all monies to which I am entitled for services rendered by them. I understand that I am ultimately financially responsible for all charges incurred by me. I agree that a photocopy of this authorization shall be as valid as the original.

INSURED OR GUARDIAN SIGNATURE _____ DATE _____

PATIENT SIGNATURE _____ DATE _____

Permission to Request Payment From Medicare

It is required to keep your signature on file, authorizing us to file claims to Medicare for you and to release information that the payer requires for the proper consideration of a claim. Please read and sign the following statement:

I authorize GROSSMONT DERMATOLOGY MEDICAL CLINIC, and any holder of medical care or other information about me, to release to the Social Security Administration and Health Care Financing Administration (or its intermediaries or carrier) any information needed for this or a related Medicare claim. I permit a copy of this 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.

_____ _____

Signature as it appears on Medicare Card Date

Permission to Request Payment from Secondary Carrier

If you have a supplemental policy and it is a Medigap policy to which your Medicare carrier automatically "crosses over", we are required to keep a separate signature on file. Please read and sign the following statement:

I request authorized Medigap benefits to be made on my behalf to be paid to GROSSMONT DERMATOLOGY MEDICAL CLINIC for any services furnished to me. I authorize any holder of medical information to release to the above Medigap carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature as it appears on Medigap Card Date

Acknowledgement of Receipt of Notice of Privacy Practices

Grossmont Dermatology Medical Clinic
Privacy Officer - 619-462-1670

Do you give Grossmont Dermatology permission to discuss your medical, billing, and account information with a friend, spouse or family member? ☐ Yes ☐ No

If yes, please provide the names of the authorized person(s) and an expiration date below:

Name: _____ Relationship: _____ Expiration Date _____
(ex. Indefinite, 2010, 2018...)

Name: _____ Relationship: _____ Expiration Date _____
(ex. Indefinite, 2010, 2018...)

Patient Signature: _____ Date: _____

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate:

Relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: _____

Grossmont Dermatology Medical Clinic Grossmont Skin Cancer Treatment Center

NAME:_____ **DATE OF BIRTH:**_____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid reflux)
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None
Other _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None

Please turn page over to complete

Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Any other family history: _____

Medications: (Please enter all current medications)

_____
_____
_____

Medication Allergies: (Please enter all allergies to medications)

_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:
Never smoked
Quit: former smoker
Smokes less than daily
Smokes daily

Alcohol Use:
Alcohol: None
Alcohol: Less than 1 drink per day
Alcohol: 1-2 drinks per day
Alcohol: 3 or more drinks per day

Pharmacy: Name:_____ Phone: _____ _____

Street: _____ City: _____ Zip Code:_____ ____

Occupation and Workplace_____

Height: _____

Weight: _____

B/P: _____

Medical Appointment Cancellation Policy

Dear Patient:

At Grossmont Dermatology Medical Clinic and the Grossmont Skin Cancer Treatment Center we strive to render excellent medical care to you and the rest of our patients. In an attempt to be consistent with this, we have implemented a Medical Appointment Cancellation Policy that better allows us to schedule appointments for all patients. By canceling your appointment at least 24-hours in advance, we are able to provide healthcare to other patients by re-booking the vacated slot. No-show or late cancellations of medical appointments result in unused appointments. This significantly decreases appointment availability for all of our patients. The necessity of rescheduling the missed treatment also ties up future appointments, further diminishing the availability of care for others.

Our policy is as follows:

We request that you please give our office a minimum of 24 hour notice in the event that you need to reschedule your appointment with a physician or Physician Assistant. This allows other patients needing care to be scheduled into that appointment. It also makes it possible to reschedule your appointment more efficiently, so that you don't have to wait too long for your next appointment. If a patient does not give at least a 24-hour notice when canceling or misses an appointment without contacting our office, a fee may be charged to you for a missed appointment.

If a patient accumulates a total of three (3) consecutive missed appointments, the patient may not be rescheduled for future appointments.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your continued patronage.

I have read and understand the Medical Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____

Signature of Patient or Responsible Party if a Minor **Date**