APEX
DERMATOLOGY

Patient Information

Name _____ SSN# _____

Address _____ City _____ State _____ Zip _____

Home# ( )_____ Cell# ( )_____ Email _____

Date of Birth ____/____/____ Gender ☐ Male ☐ Female Marital Status _____

Emergency Contact _____ Relationship _____ Phone: ( )_____

Primary Insurance _____ Policy Number _____

Secondary Insurance _____ Policy Number _____

Insurance Policy Holder

Responsible Party Name_____ Relationship_____

Address_____ City/State/Zip _____ Phone#_____

SS#_____ Date of Birth ____/____/____ Employer_____

**Payments of co-pays & private pay fees are due at time of service. If your insurance company does not make remittance within 60 days after services are rendered, the balance will be forwarded to you.

**I understand that Apex Dermatology does not participate with Medicaid, there fore I am responsible for any and all remaining balances.

**I hereby authorize payment of the surgical and/or medical benefits directly to the physician. I also understand I am responsible for any portion of the bill not covered by my insurance or not paid within 60 days.

**I hereby authorize release of information for insurance claim purposes; copy of the above is as valid as the original. I understand all of the above and hereby state that the information is correct to the best of my knowledge. My signature indicates that I have read and agree to the above and grant the request of authorization.

Signed _____ Date _____

APEX DERMATOLOGY
32144 AGOURA RD, SUITE 112, WESTLAKE VILLAGE, CA 91361
TEL (818) 889-APEX FAX (818) 889-2747

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Name: _____

Notice of Privacy Practices Acknowledgement Form

The notice of privacy practices describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully, as it explains:

- How this office will use and disclose your protected medical information.
- Your privacy rights with regard to your protected health information.
- This office's obligations concerning the use and disclosure of your protected health information.

I acknowledge that I have received a copy of the office Notice of Privacy Practices and understand my rights as well as the doctors' rights. I agree to allow my doctor to exercise their right and disclose my Individually Identifiable Health Information (IIHI) when required to do so by law. I further acknowledge that the office Notice of Privacy Practices is available at the front desk upon request.

_____ Date _____

Signature of Patient

_____ Date _____

Signature of Parent/Guardian (if patient is under 18 years old)

Please initial your preference:

_____ I give permission for detailed phone messages to be left with a person or machine answering at this number: ( )_____.

_____ I give permission to receive text messages at this number: ( )_____.

_____ I do **NOT** give permission to leave messages regarding my medical care.

Do you give permission to discuss your account with any family member? ☐ Yes ☐ No

Name _____ Relationship _____

Date of Birth of Family Member___/___/_____ **OR:** Last four digits of their Social Security #_____

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Name: _____

History and Intake Form

Name _____ Date of Birth ___/___/___ Purpose of visit_____

Referred By _____ Primary Physician _____

Employer _____ Occupation _____ Hobbies (optional) _____

Past Medical History: (Please check all that apply)

☐Anxiety
☐Arthritis
☐Artificial joints
☐Defibrillator
☐Atrial fibrillation
☐Coronary Artery Disease
☐Depression
☐Diabetes
☐End Stage Renal Disease
☐Hearing Loss
☐Pacemaker
☐Valve Replacement
☐HIV/AIDS

Past Surgical History: (Please check all that apply)

☐Breast Implants
☐Organ Transplant
☐Joint Replacement
☐Other _____

Skin Disease History: (please check all that apply)

☐Acne
☐Actinic Keratosis
☐Hay Fever/Allergies
☐Eczema
☐Psoriasis
☐Dry Skin
☐Melanoma
☐Atypical Moles

Skin Cancer: ☐Basal Cel ☐Squamous Cel ☐Melanoma

Do you wear Sunscreen? ☐ Yes ☐No If yes, what SPF? _____
Do you tan in a tanning salon? ☐ Yes ☐No If yes, how often?_____
Do you have a family history of Melanoma? ☐ Yes ☐No If yes, which relative? _____

Medications: (Please list all current medications or supplements)

_____

_____

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Name: _____

Allergies: (Please list all allergies)_____

Social History: Tobacco use? ☐ Current ☐ Past ☐ Never Current drug use?_____

Alerts: (please check all that apply)

☐Allergy to Adhesive
☐Allergy to topical antibiotics
☐Allergy to latex
☐Artificial joint replacement
☐Defibrillator
☐Pacemaker
☐Require antibiotics prior to a surgical procedure
☐Allergy to lidocaine
☐Artificial heart valve
☐Blood thinners
☐MRSA
☐Breastfeeding
☐Pregnant or trying to get pregnant?
☐Rapid heart beat with epinephrine

Are you currently experiencing any of the following? (Please check all that apply)

☐Rash ☐Changing Mole ☐Joint aches / pain / swelling
☐Muscle weakness ☐Hay fever/seasonal allergies ☐Fever / chills
☐Bleeding Problems ☐Healing Problems

Dr. Harp participates in Sure Scripts. Please supply the following information:

Pharmacy Name: _____ Phone: ( )_____

Pharmacy Address: _____ Fax: ( )_____

Let us know if you would like updates from Apex Dermatology (optional):

- ☐ I would like to receive information about the practice, events, or skin health by email.
- ☐ I would like to receive information about cosmetic events and special offers by email.

Please check all that apply:

- ☐ I am bothered by wrinkles, spots, skin tags and/or broken blood vessels.
- ☐ I would like to discuss options to make me look more youthful and/or rested.
- ☐ I would like to learn more about products that will refresh, renew and restore my skin.

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Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel or reschedule an appointment. If that happens, we respectfully ask for appointments to be cancelled at least 24 hours in advance.

Our doctors want to be available for your needs and the needs of all our patients. When a patient does not arrive for a scheduled appointment, another patient loses an opportunity to be treated. Therefore, you will be charged a $50 fee if you do not cancel 24 hours in advance.

Thank you for being a valued patient and for your understanding and cooperation. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

I understand and accept the Cancellation Policy for Apex Dermatology and agree to the $50 cancellation fee if I do not give 24 hours notice.

Print Name: _____ Date: _____

Signature: _____

Cultural Background Information (optional)

We would like you to tell us your racial and ethnic background so that we can periodically review our patient data and make sure that everyone is receiving the highest quality of care. This information is collected for the Federal electronic medical record assessment system. Your cooperation is greatly appreciated.

Which category best describes your race/ethnicity?

- ☐ White / Caucasian
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Hispanic/Latino
- ☐ Black or African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Decline to answer

What is your primary language?

- ☐ English
- ☐ Other _____
- ☐ Decline to answer

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