DEHESA DERMATOLOGY

DERMATOLOGY-RHEUMATOLOGY-PLASTIC SURGERY-INFUSION CENTER-RESEARCH

Phone: 559.951.9000 | Fax: 559.234.6334
978 N Temperance | Clovis, CA 93611

_____ has an appointment on

Monday Tuesday Wednesday Thursday Friday

Date: _____ at _____ AM/PM

Please give us at least 24-hour notice for any appointment changes to avoid a cancellation fee.

Luis Dehesa, M.D.- General Dermatology, Surgery, MOHS Surgery

Sheila Mayo, PA-C/MMSc- General Dermatology

David Mapes PA-C- General Dermatology

Milena Cavalcante M.D.- Rheumatology, Infusions

Duncan Mackay M.D.- Plastic Surgery

Please arrive 15 minutes prior to your scheduled appointment time.

Please bring the following to your appointment:

- Photo ID and Insurance Cards
- List of current medications
- Completed paperwork

If you have any questions about your appointment, please contact us at **559.951.9000**

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PATIENT REGISTRATION INFORMATION

Please PRINT and complete ALL sections below.

PERSONAL INFORMATION

Today's Date: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Gender:** ☐ Male ☐ Female ☐ Other, specify _____

Name: _____
Last Name First Name Middle Initial Maiden Name

Street Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____/_____/_____ Social Security Number: _____

Email Address: _____

RESPONSIBLE PARTY INFORMATION If self, please check box and go to insurance section below

☐ Self ☐ Spouse ☐ Parent ☐ Male ☐ Female ☐ Other, specify _____

Spouse/Parent Name: _____ Date of Birth: _____/_____/_____

Billing Address: _____ City: _____ State: ___ Zip: _____

Home Phone: _____ Cell Phone: _____

INSURANCE INFORMATION Please present all insurance cards and notify us of changes in insurance

Primary Insurance	Secondary Insurance
Primary Insurance: _____	Secondary Insurance: _____
ID #: _____	ID #: _____
Group #: _____	Group #: _____
Insured Name: _____	Insured Name: _____
Insured DOB: _____	Insured DOB: _____
Do you have an HSA/FSA? _____	

PERSONAL REPRESENTATIVE

I authorize the following person(s) to receive or know information regarding my health care or make health care decisions for me, should I become unable to make them for myself. This authorization may be revoked in writing at any time.

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

- I hereby give consent for medical/surgical treatment to the care providers with Dehesa Dermatology.
- I authorize the release of information to facilitate treatment, payment or health care operations.

_____ Date: _____

Patient Signature (or Responsible Party Signature)

"The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov." While no physician takes compensation for prescribing medications, our physicians teach other physicians about the medications and are therefore compensated.

At Dehesa Dermatology, we are committed to excellence in meeting your health care needs. We understand that billing and payment for medical services can be confusing and sensitive, and we encourage you to review our financial policies carefully. Our team is happy to answer any questions you may have. Patients are responsible for all applicable co-payments, deductibles, and co-insurance. In accordance with our contract with your insurance provider, payment is due at the time of your appointment.

_____**Deductibles:** If you have not met your deductible, it is our policy to collect, at the time of your appointment, for services we know will not be paid by your insurance. We do not guarantee that the amount paid at the time of service settles your bill with us.

_____**Non-Covered Services:** Please be aware that there may be services rendered at your appointment that are not covered by your insurance. Hair loss, skin tags, and the removal of benign growths are common conditions that may not be paid by insurance companies; you may receive a bill from our office for these services. Please be aware that anything excised from your body will be sent out to a dermatopathologist and you may receive a separate bill from that office.

_____ **Referrals/Pre-Authorizations**: It is your responsibility to obtain a current referral/pre-authorization for treatment, should your insurance dictate that one is necessary. In the absence of the appropriate documentation, you agree to accept full responsibility for the charges related to treatment.

_____**Proof of Identification/Proof of Insurance:** You will be asked to provide us with a copy of your ID and insurance cards for your chart. Please understand that we are helping to protect your identity as a patient. We are also required to send a copy of your insurance and ID to pharmacies for your prescriptions and a copy must accompany any pathology that may be sent out for testing.

_____**Payment:** If you do not have insurance and would like to be seen, we accept cash, check, VISA, Discover or MasterCard; all payments are due at the time of your appointment. A $25 fee will be added to any check that is returned for insufficient funds. Once we have received notification/payment from your insurance company, we will send you a statement. All balances are due upon receipt of the statement. It is never our intent to send a patient to collections for non-payment; please contact the billing office if you have any questions regarding your bill.

_____**No-Show/Late Cancellation/Surgeries:** We understand there may be times when you miss an appointment due to illness or emergencies. However, we ask that you call 24-hours prior to your appointment to make changes or cancel your appointment.
Please understand that because appointment time slots are valuable, you will be charged a $35 no show/late cancellation fee if you do not give a 24-hour notice. This must be paid before you are scheduled for a future visit. If you are scheduled for any surgical procedure, or require an interpreter at your appointment, we require a 72-hour notice to cancel or reschedule. You will be charged a $300 fee if you do not give 72-hour notice. If Translation services are needed for an appointment, we require a 48-hour cancellation notice or any Translation fees will be charged to the patient.

_____**Consent to Photograph:** We will be asking permission to take your photo. Please understand that this is to be used for identification purposes and will aid us in keeping track of areas of concern for future treatment. We *WILL NOT* publish your photos without your permission. If a provider would like to use a photo to be used for medical education, you will be asked to sign a separate consent form to do so.

_____ **Medical AL-scribe Assist**: I understand that an AI-assisted medical scribe may be used during my visit to help document the encounter. This technology is designed to transcribe and summarize the conversation between myself and my provider in real time.

- I have read the policies set forth by Dehesa Dermatology. My signature below signifies my understanding and willingness to comply with your policies.

_____Date:_____

Patient Signature (or Responsible Party Signature)

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NEW PATIENT MEDICAL HISTORY

Name: _____ Date: _____ Age: _____

Pharmacy Name: _____ **Cross Streets:** _____

Medical History: In your own words, please state the reason for your visit **(chief complaint)**: _____

_____

_____

How long have you had this problem? **(duration)** _____

What parts of your body are affected? **(location)** _____

What makes it better? What makes it worse? **(change in severity)** _____

_____

How does this problem bother you? **(symptoms)** _____

What treatments have you received for this problem? **(previous therapy)** _____

_____

_____

Is your problem ☐ worsening? ☐ stable? ☐ improving? **(timing)** Explain: _____

_____

_____

Past medical/family/social history: Please list all past major illnesses and operations: _____

_____

_____

Please list all medications you are currently taking: _____

_____

Please list all drug and environmental allergies: _____

_____

Is there a family history of a condition similar to yours? ☐ Yes ☐ No Additional Information: _____

_____

Is there a family history of (please mark the square(s) that apply): ☐ adult acne ☐ asthma ☐ diabetes
☐ eczema ☐ hay fever ☐ genetic disease ☐ hair loss ☐ melanoma ☐ psoriasis ☐ skin cancer
Additional information: _____

Occupation: _____

Do you smoke? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No

Review of Symptoms

Skin: Have you seen a doctor for other skin problems? ☐ Yes ☐ No Which one(s)? _____

_____

Do you have (please mark square(s) that apply: ☐ hair loss ☐ skin cancer ☐ abnormal moles

When you are exposed to sunlight, do you:

1. ☐ Always burn
2. ☐ Usually burn, rarely tan
3. ☐ Often burn, tan slowly
4. ☐ Sometimes burn, tan well
5. ☐ Rarely burn, always tan
6. ☐ Never burn, deeply tan

Women: Are you pregnant? ☐ Yes ☐ No Do you plan to become pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Mark square next to any symptom or condition you are having:

General

☐ fever
☐ chills
☐ weight loss
☐ loss of appetite
☐ fatigue

Head, Eyes, Ears, Nose, Throat

☐ dry eyes
☐ eye disease
☐ ringing in ears
☐ ear disease
☐ bloody nose
☐ stuffy nose
☐ swallowing difficulties
☐ dry mouth
☐ sore mouth
☐ mouth ulcers

Cardiovascular

☐ pacemaker
☐ heart disease
☐ mitral valve prolapse
☐ hypertension
☐ chest pain

Respiratory

☐ cough
☐ difficulty breathing
☐ lung disease
☐ tuberculosis
☐ coughing up blood

Gastrointestinal

☐ liver disease
☐ intestinal disease
☐ heartburn/indigestion
☐ abdominal/stomach pain
☐ diarrhea
☐ constipation
☐ blood in stool/black stool
☐ nausea
☐ vomiting

Genitourinary

☐ kidney disease
☐ bladder disease
☐ blood in urine/dark urine
☐ female problems
☐ stillbirth/spontaneous abortion
☐ problems with urination

Musculoskeletal

☐ joint aches
☐ swollen joints
☐ muscle aches
☐ muscle weakness
☐ back pain
☐ ankle swelling
☐ fingers sensitive to cold

Neurologic

☐ epilepsy/seizures
☐ headaches
☐ stroke
☐ dizziness
☐ disorientation
☐ confusion
☐ memory loss
☐ double vision
☐ loss of consciousness

Psychiatric

☐ nervous breakdown
☐ depression
☐ insomnia

Endocrine

☐ diabetes
☐ enlarged glands
☐ hormonal problems
☐ thyroid disease

Hematologic/Lymphatic

☐ anemia
☐ free bleeding tendency

Immunologic

☐ immune deficiency
☐ frequent infections

If needed, please elaborate on any of the above: _____

_____

_____

_____ Date: _____

Patient Signature (or Responsible Party Signature)

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

THE NOTICE OF PRIVACY PRACTICE 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 health 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 the office Notice of Privacy Practices is available at the front desk upon request. I have read and understand those rights.

_____ _____

Patient or Patient Representative Signature Date

_____

Patient or Patient Representative Printed Name