ED OC ENHANCED DERMATOLOGY ORANGE COUNTY
MEDICAL | SURGICAL | COSMETIC

DR. JAY APPLEBAUM DR. MARY JUNG
DR. KAROL DANGARAN DR. WIEKE LIEM

Today's Date_____ Appointment Date_____

Last Name _____ First Name _____ Middle Initial _____
Birthdate_____ Age_____ Title: (circle one) Mr. Mrs. Dr. Ms. Miss Sex: (circle one) M F
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell _____ Work _____
Email _____ SS# _____
May we leave a detailed voicemail? YES NO Marital Status (circle one) Single Married Separated Divorced Widowed
Occupation _____ How did you hear about us? _____
Primary Care Physician: (LAST) _____ (FIRST)_____ Phone_____
Address_____ (City)_____ State_____ Zip_____
Referring Physician: (LAST)_____ (FIRST)_____ Phone_____
Address_____ (City)_____ State_____ Zip_____

IN CASE OF EMERGENCY
Name _____ Relation _____ Phone_____

IF PATIENT IS A MINOR
My signature below authorizes Enhanced Dermatology to provide any necessary treatment for my child until I notify in writing that my permission is revoked.

PLEASE LIST YOUR PHARMACY (For e-prescribing purposes)
Pharmacy Name_____ Phone_____ Address (or major cross streets if not known)
May we obtain your prescription history directly from your pharmacy? YES NO

INSURANCE
Primary Insurance_____ ID
Policy Holder Name_____ Policy Holder DOB_____ SS_____
Patient's relationship to policy holder (circle one) Self Spouse Child Other
Secondary Insurance_____ ID
Policy Holder Name_____ Policy Holder DOB_____ SS_____
Patient's relationship to policy holder (circle one) Self Spouse Child Other

PAST MEDICAL HISTORY: ☐ NONE

☐ Anxiety	☐ Depression	☐ Hyperthyroidism (overactive)
☐ Arthritis	☐ Diabetes	☐ Hypothyroidism (underactive)
☐ Asthma	☐ End Stage Renal Disease	☐ Leukemia
☐ Atrial Fibrillation	☐ GERD	☐ Lung Cancer
☐ BPH	☐ Hearing Loss	☐ Lymphoma
☐ Bone Marrow Transplant	☐ Hepatitis - A/B/C	☐ Prostate Cancer
☐ Breast Cancer	☐ HIV-AIDS	☐ Radiation Treatment
☐ Colon Cancer	☐ Hypercholesterolemia	☐ Seizures
☐ COPD	☐ Hypertension	☐ Stroke
☐ Coronary Artery Disease		

Other Important Medical History_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand I am responsible for any balance. I also authorize Enhanced Dermatology or the insurance company to release any information required to process my claims.

Patient or Parent/Guardian Signature_____

NAME _____ Today's Date _____

PAST SURGICAL HISTORY: ☐ NONE

☐ Appendix (Appendectomy)
☐ Bladder (Cystectomy)
☐ Breast: Mastectomy (Right, Left, Bilateral)
☐ Breast: Lumpectomy (Right, Left, Bilateral)
☐ Breast: Breast Biopsy (Right, Left, Bilateral)
☐ Breast: Breast Reduction
☐ Breast: Breast Implants
☐ Colon: Colon Cancer Resection
☐ Colon: Diverticulitis
☐ Colon: Inflammatory Bowel Disease
☐ Gallbladder Removed
☐ Heart: Coronary Artery Bypass (CABO)
☐ Heart: PTCA (Angioplasty)
☐ Heart: Mechanical Valve Replacement
☐ Heart: Biological Valve Replacement
☐ Heart Transplant
☐ Knee Replacement (Right, Left, Bilateral)
☐ Hip Replacement (Right, Left, Bilateral)
☐ Kidney Biopsy
☐ Kidney Removed: (Right, Left)
☐ Kidney Stone Removal
☐ Kidney Transplant
☐ Ovaries Removed: Endometriosis
☐ Ovaries Removed: Cyst
☐ Ovaries Removed: Cancer
☐ Prostate Removed: Cancer
☐ Prostate: TURP
☐ Skin: Basal Cell Carcinoma Surgery
☐ Skin: Squamous Cell Carcinoma Surgery
☐ Skin: Melanoma Surgery
☐ Spleen Removed
☐ Testicles Removed (Right, Left, Bilateral)
☐ Uterus (Hysterectomy): Fibroids
☐ Uterus (Hysterectomy): Uterine Cancer

Other Important Surgical History_____

SKIN DISEASE HISTORY: ☐ NONE

☐ Acne ☐ Blistering sunburns ☐ Flaking or Itchy Scalp ☐ Precancerous Moles
☐ Actinic Keratosis ☐ Dry Skin ☐ Melanoma ☐ Psoriasis
☐ Basal Cell Skin Cancer ☐ Eczema ☐ Poison Ivy ☐ Squamous Cell Skin Cancer

Other_____

BCC or SCC: Year_____ Location_____ Treatment_____
Melanoma: Year_____ Location_____
Treatment_____
Do you wear Sunscreen? Yes No Have you ever tanned in a tanning salon? Yes No
Do you have a family history of Melanoma? Yes No Who? Mother Father Brother Sister
If YES to melanoma, any other family history of cancers (breast, ovarian, pancreatic)? Yes No Who? Mother Father Brother Sister

ALLERGIES TO MEDICATIONS: (please list drug allergies & reactions) ☐ NONE

_____ _____

MEDICATIONS/SUPPLEMENTS: (please list all current medications & strengths) ☐ NONE

_____ _____
_____ _____
_____ _____
_____ _____

SOCIAL HISTORY:

IV Drug/Drug Use: Yes No Smoking Use: Never Alcohol Use: None
Currently smokes - daily Less than 1 drink/day
Currently smokes - not daily 1-2 drinks/day
Has smoked in the past 3 or more drinks/day

Have you had the pneumonia vaccine (Pneumovax) ☐ Yes ☐ No?
If YES, when did you receive it?_____
Did you receive the flu vaccine this year? ☐ Yes ☐ No
If not, what was the reason?_____
Do you have an Advance Care Plan? ☐ Yes ☐ No
If so, what is the name of your Surrogate Decision Maker?_____

Did you receive the covid vaccine? ☐ Yes ☐ No

ARE YOU INTERESTED IN ANY COSMETIC PRODUCTS AND/OR PROCEDURES? YES NO

CO-PAYMENT AND DEDUCTIBLES

Payment is required for all services at the time they are rendered. Co-payments will be collected at the time of service. I understand that in the event that my services are not covered under my insurance, I accept full financial responsibility of those non-covered services. An administrative billing fee of $10 will be applied if co-payments are not paid at the time of service. In the event that your account must be turned over for collections, interest and/or a collection fee at the provider's current rate may be charged on all balances owing that are past due. I further acknowledge that I am responsible for the co-insurance and/or deductible under my health plan's agreement and should my account be sent to a collection agency, I shall be responsible for the collection agency fee or the actual collection cost. Your signature below signifies understanding of this policy.

REFERRAL POLICY

If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my primary care provider and assure that it is available at the time of my visit. I further understand that it is my responsibility to keep track of the number of visits I have used, the expiration date, and obtain a new referral as needed. I understand that should I fail to have a valid referral at the time of my visit, I will need to reschedule my appointment.

PHOTOGRAPHY

I give my permission for digital photographs to be included in my electronic medical record._____INITIAL

PATHOLOGY

I give my permission to send pathology reports and/or biopsy slides to outside physicians/labs if needed for additional review, surgery, or diagnosis. I am aware that there would be an additional charge for this service._____INITIAL

CANCELLATION POLICY

Should you be unable to keep your appointment, please contact our office to cancel your appointment at your earliest convenience. Failure to contact our office within 24 hours of the appointment will result in a $50.00 no-show fee. This fee is not reimbursable by your insurance company.

HIPAA POLICY

Patients 18 years of age or older are protected under the Federal Health Insurance Portability and Accountability Act. This federal law prohibits any staff member of Enhanced Dermatology from discussing appointments, medications, test results, and/or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or care takers to obtain information on their behalf. If you would like to permit someone to discuss your medical condition or obtain results for you, please list their name(s) below. Only individuals names listed will be provided with information. Should you wish to update the names provided, please ask the receptionist at the front desk for a HIPAA form.

Name of Individual_____

Name of Individual_____

Name of Individual_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was given the opportunity to review the Notice of Privacy. I understand a copy of the Privacy Practices is available upon my request (please ask our front desk staff).

Patient Signature: _____ Date: _____

Must be signed by patient 18 years or older. Patients under 18, must be signed by a parent or legal guardian.