PATIENT INFORMATION

ALL INFORMATION MUST BE COMPLETED IN ALL FIELDS PRIOR TO YOUR APPOINTMENT WITH THE DOCTOR.

□ **New Patient** □ **Name Change** □ **Address Change** □ **Insurance Change**

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS

Name: _____
LAST FIRST M.I.

Date of Birth: _____/_____/_____ Age: _____ Sex:□ Male □ Female

S. S.#:_____-____-_____ Drivers Lic #_____ STATE _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Ph# ( ) _____ Cell Ph# ( ) _____

Work # ( ) _____

PARENT, SPOUSE, OR RESPONSIBLE PARTY (if different from patient)

Name: _____ Date of Birth: ___/___/____
LAST FIRST MI

Mailing Address: _____

_____
CITY STATE ZIP

INSURANCE CARRIER INFORMATION:

Primary Insurance Carrier: _____

Secondary Insurance Carrier: _____

PLEASE SIGN SO THAT WE MAY HAVE YOUR INSURANCE AUTHORIZION ON FILE.

I authorize any holder of medical or other information about me to release to the above insurance company(s) any information needed for this or a related insurance 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 the party who accepts assignment.

Date: _____/_____/_____ Signature: _____

Please provide your insurance card(s) and drivers license to the receptionist along with this form.

MEDICAL HISTORY

Patient: _____ Date: _____

Reason for today's visit: _____

Are you allergic to any medications? ◻ YES ◻ NO If yes, list: 1._____

2._____ 3. _____ 4._____

List all medications you are currently taking:

1._____ 2. _____

3._____ 4. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	**YES**	**NO**	**Other Systemic**	**YES**	**NO**
Bronchitis	◻	◻	Diabetes	◻	◻
Emphysema	◻	◻	Thyroid	◻	◻
Asthma	◻	◻	Kidney	◻	◻
Chronic Cough	◻	◻	Bladder	◻	◻
Morning Cough	◻	◻	Stomach	◻	◻
			Bowel	◻	◻
Vascular			patitis or yellow skin	◻	◻
			Glaucoma	◻	◻
High Blood Pressue	◻	◻	Arthritis/Joint Deformity	◻	◻
Chest Pain	◻	◻	Convulsions, Epilepsy		
Heart Attack	◻	◻	or Seizures	◻	◻
Heart Murmur	◻	◻	Fainting	◻	◻
Irregular Heart Beat	◻	◻			
Pacemaker	◻	◻			
Phlebitis	◻	◻			

List any other disease or condition we should know about:

_____

Do you drink alcohol? ◻ YES ◻ NO If YES _____ drinks per day

Do you use IV drugs? ◻ YES ◻ NO If YES what? _____How much?_____

Have you ever had dental anesthesia (Novacaine)?◻ YES ◻ NO Any bad reaction? ◻ YES ◻NO

SKIN:

When you are exposed to sun do you: ◻ Tan only ◻ Tan and Burn ◻ Burn

Have you ever had skin cancer? ◻ YES ◻ NO

Has anyone in your family had skin cancer? ◻ YES ◻ NO If YES who? _____

Do you have a history of any specific skin diseases? ◻ YES ◻ NO

If yes please list : _____

Please answer the following questions:

A. Do you smoke? ◻ YES ◻ NO If YES how much? _____

B. Do you bleed easily? ◻ YES ◻ NO

C. (Women) Are you pregnant? ◻ YES ◻ NO If yes due Date _____

D. Do you have artificial joint(s)? ◻ YES ◻ NO

E. What is your occupation? _____

F. What are your hobbies? _____

Completed by: ◻ patient

◻ Medical assistant _____ Initials

_____ signed by Physician Date

_____ Reviewed by Date

PATIENT FINANCIAL POLICY & SIGNATURE ON FILE

Name: _____ Todays Date: ___/___/___
Last First MI

Referred by: _____

Primary Care Physician: _____Phone (____)_____

Pharmacy Name: _____ Phone(____)_____

EMERGENCY CONTACT INFORMATION

In case of emergency, who should be notified? _____Phone:_____

Relationship to patient: _____

Do you give our office permission to discuss your medical information with family members?

□YES □ NO If yes, please provide their names and phone numbers below.

Name: _____ Relationship: _____

Phone # (day): ( ) _____ Phone # (evening): ( )_____

May we leave personal medical information on your answering machine or cell phone? □ YES □ NO

May we e-mail personal medical information to you? □ YES □ NO

E-Mail address: _____

RECEIPT OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature _____ Date____/____/____

Payment Policy:

HMO, PPO, or other managed care patients: You will be responsible for paying your annual deductible, copayment and charges for any non-covered, cosmetic services at the time of service.

Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 50% of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patient or Responsible Party Signature _____ Date____/____/___

SYRUS RAYHAN, MD Inc.

DERMATOLOGY, SKIN CANCER, AND LASER SURGERY

Consent Form for Medical Information Disclosure

In connection with the medical services that I am receiving from the above-named physician/provider, I hereby authorize the above –named physician/provider to disclose any or all information concerning my medical condition and treatment including copies of applicable hospital and medical records to:

A. Any third party payer covering the medical services of the patient.
B. Other health care professionals and institution involved in the delivery of health care to the patient.
C. The proponent of any legally sufficient subpoena or in response to a court order.
D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services.
E. Pharmacies
F. Other parties as otherwise required by the law.

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above.

I am consenting to receive my medical information by the following communication method. Please check all that apply:

__ Telephone conversation, __ Telephone message on o my home answering machine.
Home Phone number: _____

__ Telephone message on my office voicemail. Work Phone Number: _____

___ Leave telephone messages with: (name of individuals who are authorized to receive your medical information by phone: _____

__ Telephone message on my cell phone. Mobile Phone Number: _____

I consent to have my medical information discussed with:

Please check all that apply and include name:

__ Spouse: _____ __ Parents: _____

__ Children: _____ __Other _____

I consent to have my medical information shared with my physicians:

Please check all that apply

___ Primary care Physician: _____

___ Other Physician: _____

This consent is valid from the date executed until revoked in writing by the patient.

Signature: _____ **Date:** _____

If person other than patient is signing please print full name and indicate relationship below.

Print full name: _____ **Relationship:** _____

FINANCIAL POLICIES OF SYRUS RAYHAN, M.D., Inc.

17822 BEACH BLVD. #136
HUNTINGTON BEACH CA 92647
TEL: (714)847-1277
FAX: (714)843-2000

PLEASE INITIAL EACH LINE AFTER YOU HAVE READ AND UNDERSTAND EACH INDIVIDUAL POLICY.

PATIENT'S NAME: _____

DATE: _____

_____ **PAYMENTS:** Payments are due at the time of service.

_____ **CO-PAYMENTS, DEDUCTABLES:** These are due at the time of service. If you choose to be billed for any of these charges, a $25.00 charge will be added to your account.

_____ **MISSED APPOINTMENTS:** A missed appointment fee of $20.00 for office visits and $40.00 for all surgical procedures will be charged if the office is not notified 24 hrs. in advance. This fee is not covered by insurance and therefore will not be billed to your insurance company.

_____ **MEDICAL RECORDS:** If you would like your medical records from us, please submit a written authorization to our office. You can mail this letter to us. You will also be charged $15.00 - $30.00 (depending on the size of your chart) for this service. Please allow 15 days from receipt of this request.

_____ **PRESCRIPTION REFILLS:** Prescriptions need to be written at the time of service. Failure to do so, the prescription must be faxed from the pharmacy and will take approximately 7-10 working days. We will be unable to respond to request received over the weekend until the following business day. **Doctor will not refill your prescriptions if you have not been seen in the last 6 months**

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND AGREE TO THE STATEMENTS ABOVE.

PATIENT/GUARDIAN SIGNATURE: _____
DATE: _____

SYRUS RAYHAN, M.D., INC.
17822 BEACH BLVD. #136
HUNTINGTON BEACH, CA 92647
TEL: 714-847-1277
FAX: 714-843-2000

NOTICE IF PRIVACY PRACTICES:

Acknowledgment of Receipt

By signing this form, you acknowledge receipt of the **Notices of Privacy Practices** of Syrus Rayhan M.D. Our Notice of **privacy practices** provides information about how we can use and disclose your protected health information. We encourage you to read it in full.

Our Notice of **privacy** is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office at (714) 847-1277.

I acknowledge receipt of the **Notice of privacy practices** of Syrus Rayhan M.D.

Signature_____Date_____
(parent /patient/conservator/guardian)

FOR OFFICE USE ONLY

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment and the reason why the acknowledgment was not obtained.

Signature of provider representative:_____Date_____

( ) Individual refused to sign

() Communication barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (please specify)

NOTICE OF PRIVACY PRACTICES

We Care About Your Privacy

Syrus Rayhan, M.D., INC.
Dermatology
17822 Beach Blvd, Suite 136
Huntington Beach, CA 92647

1. Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. Our Legal Duty

Law Requires Us to:

1. Keep your medical information private
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practice:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. Use and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at anytime by writing to us.

For Treatment:

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment:

We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

For Health Care Operations:

We may use and disclose your medical information for our health care operations. This might include a measuring and improving quality, evaluating the performance of employees conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional Uses and Disclosures:

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.