ROCKLIN DERMATOLOGY

New Patient Demographics

First Name:_____M.I.___ Last Name:_____Preferred Name:_____

Sex: ❒ Male ❒ Female Gender Identity: _____ Pronouns: ❒ He/Him ❒ She/Her ❒ They/Them

Birth Date: _____ Age:___ Soc. Sec. #: _____ Email:_____

Address: _____City:_____State:___Zip:_____

Primary Phone #: (____)_____ ❒ Cell ❒ Home ❒ Work

Secondary Phone #: (____)_____ ❒ Cell ❒ Home ❒ Work

Can our office leave a voicemail/text message regarding appointments? ❒ Yes ❒ No

Primary Language Spoken:_____ Race:_____

Ethnicity:_____

Have you ever been a patient of our practice? ❒ Yes ❒ No Referred By:_____

Primary Care Provider:_____ Primary Care phone #:(____)_____

Pharmacy:_____Location:_____ Phone #:(____)_____

Employment Status: ❒ Full Time ❒ Part Time ❒ Unemployed ❒ Student

Marital Status: ❒ Single ❒ Married ❒ Widowed ❒ Divorced ❒ Life Partner

Emergency Contact

Emergency Contact: _____ Relation:_____Phone #:(____)_____

Do we have permission to contact/leave medical information with your emergency contact? ❒ Yes ❒ No

If yes, select the information: ❒ Appointments ❒ Results ❒ Billing ❒ Diagnosis ❒ Complete Record

Insurance (if self-pay disregard following section)

Who is the Responsible Party for Medical Insurance? ❒ Self ❒ Other If under 18: ❒ Guardian

If Other/Guardian, Subscriber Information:

Name:_____Relation:_____Birth Date:_____ Phone #:(____)_____

Address: _____ City: _____ State:___Zip:_____

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Medications

Are you on any blood thinning medication? YES NO Name:_____

Are you on any immunocompromising medications? YES NO Name:_____

Past and Current Medical Conditions

❒ None
❒ Acne
❒ Actinic Keratosis
❒ Allergies
❒ Arthritis
❒ Asthma
❒ Atrial Fibrillation (A-Fib)
❒ Acne
❒ Cancer Type:_____
- ❒ Skin Cancer of Unknown Type
- ❒ Basal Cell Carcinoma (BCC) Location:_____ Date:_____
- ❒ Melanoma Location:_____ Date:_____
- ❒ Squamous Cell Carcinoma (SCC) Location:_____ Date:_____

❒Coronary Artery Disease (CAD)
❒ Depression
❒ Diabetes
❒ Eczema
❒Hair Loss disorder
❒Hepatitis
❒High Blood Pressure
❒ Hypothyroidism
❒Kidney disease
❒ Lupus
❒Peripheral vascular disease (PVT)
❒Stroke
❒Vitiligo
❒ Other: _____

Allergies

❒ No Known Drug Allergies
❒ Adhesive Tape Reaction:_____
❒ Amoxicillin Reaction:_____
❒ Aspirin Reaction:_____
❒ Bacitracin Reaction:_____
❒ Codeine Reaction:_____
❒ Iodine Reaction:_____
❒ Latex Reaction:_____
❒ Lidocaine Reaction:_____
❒ Penicillin Reaction:_____
❒ Sulfa Medications Reaction:_____
❒ Tetracycline Reaction:_____
❒ Other:_____ Reaction:_____

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Past Surgeries/Procedures

❒None
❒ Cesarean Section (C-Section)
❒ Mastectomy
❒ Basal Cell Carcinoma Removal
❒ Botox Injection
❒ Breast Surgery
❒ Heart Surgery
❒ Joint Replacement Surgery
❒ Melanoma Removal
❒ Squamous Cell Carcinoma Removal

Have you been Hospitalized in the last 12 months? YES NO Reason: _____

Family History

❒ None
❒ Autoimmune Disease Family Member:_____ Disease: _____
❒ Eczema Family Member:_____
❒ Heart Disease Family Member:_____
❒ Psoriasis Family Member:_____
❒ Skin Cancer Family Member:_____ Type of Cancer:_____

Social History

Smoking Status: ❒ Daily ❒ Weekly ❒ Occasionally ❒ Rarely ❒ Former Smoker ❒ Never Smoked

Alcohol Intake Frequency: ❒ Daily ❒ Occasionally ❒ Rarely ❒ Never

Recreational Drug User: ❒ Current ❒ Former ❒ Never ❒ Decline to Answer

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Patient Acknowledgement & Agreement

Privacy Practices Summary

Your health information is protected under federal laws, including HIPAA and HITECH. We are committed to maintaining your privacy and will only use or disclose your medical information for:

- Treatment: Coordinating your care with healthcare providers.
- Payment: Billing insurance companies or you directly for services rendered.
- Healthcare Operations: Ensuring quality care and efficient practice operations.
- Legal Requirements: Complying with federal or state laws, public health concerns, or law enforcement requests.
- Other Disclosures: With your written authorization for purposes beyond those listed above.

You have the right to: inspect and request a copy of your medical records. Request amendments to incorrect or incomplete information. Restrict certain uses or disclosures of your information. Receive confidential communications in a manner of your choice. For the full Notice of Privacy Practices, please request a copy at the front desk. **Initials:** _____

Financial Policy Summary

- Insurance: While we will verify your insurance benefits, this is not a guarantee of payment. You are responsible for any changes to your plan and any unpaid balances.
- Payment Responsibility:
    - Co-pays, deductibles, and non-covered services are due at the time of service.
    - If insurance verification is unavailable, you will receive a bill for the balance.
    - Non-insured patients must pay in full at the time of service.
    - If your insurance requires a co-insurance payment, a minimum of $100 is due at the time of service, with the remaining balance billed after insurance processes the claim.
- Minors: The accompanying adult is responsible for payment. A parent or legal guardian must be present for a minor's first visit.
- Delinquent Accounts: Unpaid balances may incur finance charges.
- If a collection agency is required, you agree to pay all related fees, including attorney costs.

For the full Financial Policy, please request a copy at the front desk. **Initials:** _____

Assignment of Benefits:
I authorize payment of insurance benefits to be made directly to Rocklin Dermatology for services rendered. I understand I may be responsible for charges not covered by insurance. I further authorize Rocklin Dermatology to disclose necessary medical information to my insurance company for reimbursement purposes and release them from any liability related to this disclosure. For the full Assignment of Benefits, please request a copy at the front desk. **Initials:** _____

By signing below, I acknowledge that I have read and understand this Consent Form, and I have been informed of my right to request full copies at the front desk.

Patient Name (Printed): _____
Patient Signature: _____ **Date:** _____

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Authorization to Release Information:
I authorize Rocklin Dermatology to release and request my medical records from other healthcare providers, including my primary care physician (PCP) and any previous dermatology office or pathology service, for the purpose of obtaining payment from my insurance company or ensuring continuity of care. For the full Release of Medical Information, please request a copy at the front desk. **Initials: _____**

Information to be Released (Check all that apply):

❒ Full Disclosure including but not limited to: lab reports, intake notes, treatment notes, etc.
❒ Partial Disclosure: only including: _____

HIPAA Disclosure
I, _____, (the patient, or the guardian of the patient) hereby authorize Rocklin Dermatology to release my medical information via postal mail. Telephone, fax, or email to the following person. **Initials:** _____

Name: _____ Relationship:_____ Phone Number:_____

❒ Appointments ❒ Results ❒ Diagnosis/Treatment ❒ Billing

Medical Treatment Authorization
I, the undersigned, a patient of Rocklin Dermatology, request and authorize my attending physician and whomever he/she may designate as his/her associates or assistants, to administer such treatment as is medically necessary. I voluntarily consent to said medical care, evaluation, and treatment, as well as any information release necessary to obtain such. This would include such services, care, diagnostic procedures, and/or medical treatments as the physician deems reasonable and necessary. These would include, but not be limited to, the performance of such services involving laboratory, radiology, and injections. In the event that invasive procedures are deemed medically necessary, I further understand that additional consent will be obtained and this consent might be verbal or written as circumstances dictate. I am aware that the practice of medicine and surgery is no exact science, and I acknowledge that no guarantees have been made to me as to the results of treatment or examination. **Initials:** _____

Email Communications
I understand that I can "opt out" of receiving communications via unencrypted email by notifying Endure Urgent Care or Rocklin Dermatology in writing. By signing below, I acknowledge the risks of communicating my health information via unencrypted email and consent to receive such communications despite those risks. I also understand that messages containing clinically relevant information may be incorporated into my medical record at the provider's discretion. **Initials:** _____

Patient Arbitration Agreement
By signing, you agree to resolve any dispute over your care through binding arbitration—covering all related claims, before or after signing—rather than court or jury. You and your provider each share arbitration costs, and state-law rules on timelines and procedures still apply. You can revoke this agreement in writing within 30 days. **Initials:** _____

By signing below, I acknowledge that I have read and understand this Consent Form, and I have been informed of my right to request full copies at the front desk.

Patient Name (Printed): _____
Patient Signature: _____ **Date:** _____