NEWPORT BEACH
DERMATOLOGY &
PLASTIC SURGERY

Given Name: _____Preferred Name:_____ Date:_____

Address: _____City:_____State:_____ Zip:_____

Date of Birth:_____/_____/_____ Sex: Female / Male Height: _____ Weight: _____

Preferred Pronouns: He/His She/Her They/Them Other: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Emergency contact: *Name*: _____ *Phone:*_____

Relationship: Spouse / Child / Parent / Girl Friend / Boy Friend / Friend / Other: _____

Referred by: _____

Pharmacy (name and location): _____

Do you have an Advanced Directive: **No / Yes** If Yes, please provide our office with a copy.

Have you been vaccinated for Covid 19: **No / Yes** If yes, please provide our office with a copy. Obtain at:

https://myvaccinerecord.cdph.ca.gov/ and email to: info@newportbeachdps.com

Please list your current medications with dosage including any supplements/vitamins: ☐ **None**

_____

_____

_____

I consent to sharing information with the following person(s) until revoked in writing: ☐ **Yes** ☐ **No**
(If yes, check what information we may share)

☐ **Billing information** ☐ **Lab/Pathology Results** ☐ **Appointment Information**

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Anne Marie McNeill, MD, PhD - Christopher Ellstrom, MD, APC - Robin Lewallen, MD - Larisa Lehmer, MD
-Suchismita Paul, MD -Anny Xiao, DO- Jennifer Moller, MS, PA-C - Kristin Scord, MS, PA-C, Elizabeth Velez, MS, PA-C-
27512 Calle Arroyo, San Juan Capistrano, CA 92675 Phone: 949-706-7886 Fax: 949-706-0681

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MEDICAL HISTORY:

Do you have a history of skin cancer? **No / Yes** (If yes, was it *Basal Cell Carcinoma, Squamous Cell Carcinoma, Melanoma*, or other?) Please indicate below and list locations and year treated to the best of your ability:

Location:_____ Type:_____Year:_____

Location:_____ Type:_____Year:_____

Location:_____ Type:_____Year:_____

Do you have a family history of Melanoma in a first-degree relative (mother, father, siblings)?

(please circle one) **No / Yes / Unsure** (Who: _____)

Do you have a history of Atypical Nevi (Atypical moles) or Actinic Keratosis? (*please circle one*) **No / Yes**

Do you have a history of blistering sunburns in childhood? (*please circle one*) **No / Yes / Unsure**

Do you have a history of keloid scars? (*please circle one*) **No / Yes / Unsure**

Do you smoke? (*Please circle one*) **Never** / **Current smoker** / **Former smoker**

(How long since you last smoked? _____)

Please list any current medical problems: ☐ **None**

_____

_____

Please list your past surgeries, including cosmetic surgeries, and approximate dates: ☐ **None**

_____

_____

_____

Please list any allergies to medications or latex: ☐ **None**

_____

_____

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INSURANCE GUARANTOR INFORMATION:

Is needed if the patient is **not** the subscriber to the insurance. For example, if the patient is the spouse or child of the guarantor. If you (the patient) are not the subscriber to the insurance, please fill out the following:

Patient name: _____ Guarantor relationship to the patient: _____

Guarantor name: _____

Guarantor address: _____City:_____State:_____ Zip:_____

Guarantor birth date: _____/_____/_____ Guarantor phone number:_____

TREATMENT CONSENT

I GIVE MY CONSENT FOR EXAMINATION AND TREATMENT. The nature of many, if not most, dermatology and/or plastic surgery consultations is that an unclothed skin and body examination is indicated. Often another NBDPS staff member may be present, in general this is for both the patient and provider's protection and to assist in the patient's care. I give my consent for examination with or without another NBDPS staff member present, and treatment including biopsies, destructions, lasers, excisions and injections, as discussed with my provider.

Signature: _____Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Effective date 1/18/2010: I acknowledge that I will receive a copy of the "Notice of Privacy Practices" upon request. If there is any amended "Notice of Privacy Practices," they will be available upon request at my next appointment.

Signature: _____Date: _____

I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING PROTECTED HEALTH INFORMATION UNDER HIPAA (THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT). I understand that this information can and will be used to 1. Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly; 2. Obtain payment from third party providers; 3. Conduct normal healthcare operations such as quality assessments and physician certifications. I have been given the right to review your Notice of Privacy Practices prior to signing this acknowledgement. I understand that NBDPS has the right to change its Notice of Privacy Practices and that I may contact the organizations at any time to obtain a current copy. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you agree, then you are bound to abide by such restrictions.

Signature: _____Date: _____

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Digital Photo Consent

Federal law guarantees a patient's right to maintain privacy of medical information. Photographs taken before, during, and after medical procedures may be considered part of the medical information.

Please note that the release of all photographs, videos, illustrations, or otherwise is addressed at the time of taking your photographs for medical records kept with Newport Beach Dermatology & Plastic Surgery (NBDPS), Anne Marie McNeill MD PhD Inc. and Christopher Ellstrom, MD, APC. Please read the release thoroughly when given to you by our staff before taking your photographs.

(please select one)

- ❑ **Any and All Use:** This includes, but is not limited to: advertising, publicity or promotion in print, visual, or electronic media; communications to physicians; publication in medical journals and/or textbook for physician education; and for use in physician lectures and patient education

- ❑ **Limited Media Use:** This included use as educational photo book material for new patient consultations. Internal use for research development and quality control; communications to physicians.

- ❑ **Medical Record:** This will limit use of any digital content produced of me to Newport Beach Dermatology & Plastic Surgery (NBDPS), Anne Marie McNeill, MD, PhD Inc., Christopher Ellstrom MD, APC, as well as involved office staff.

Signature: _____Date: _____

OUR FINANCIAL POLICY FOR ALL PATIENTS

At this time, in general, payment is required for all services at the time they are rendered. If you are in an insurance plan that we participate in, in general, only applicable copayments and deductibles will be collected at the time of the service and we bill insurance for you as a courtesy. However, we do reserve the right to collect full payment from the patient for any procedures performed. The patient is responsible for any/all charges not paid by any insurance company. I agree to make in full prompt payment to Anne Marie McNeill MD PhD Inc or Christopher Ellstrom, MD, APC, when billed for any and all charges not covered or paid by insurance. Further, I authorize payment directly to the provider for medical insurance benefits payable to me under the terms of my policy. We do reserve the right to change our financial policy at any time. I have read and understand the financial policy statement.

Signature: _____Date: _____

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Credit Card on File Agreement Policy

Copays are due at the time of service. At check in, your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any. At that time, you will be sent a statement which you will have 30 days to pay. After 30 days, if the bill remains unpaid, we will bill your credit card. You have the ability to dispute a charge or question your insurance company's determination of payment.

By signing below, I authorize NBDPS to keep my signature and my credit card information securely on-file in my account. I authorize NBDPS to charge my credit card for any outstanding balances when due.

If the credit card that I give today changes, expires, or is denied for any reason, I agree to immediately give NBDPS a new, valid credit card which I will allow them to charge over the telephone. Even though NBDPS is not processing the new card in person, I agree that the new card may be used with the same authorization as the original card I presented.

Patient's Name (Print): _____DOB: _____/_____/_____

Name on Card (Print): _____

Billing Address:_____City:_____State:_____Zip:_____

Credit Card Number: _____ Exp. Date: _____/_____ Security Code:_____

Please fill out information below for any other person(s) you authorize this credit card for:

Patient Full Name (Print): _____ DOB: _____/_____/_____

Patient Full Name (Print): _____ DOB: _____/_____/_____

Card Holder's Signature: _____ Date: _____

□ Please check this box if you prefer not to receive a statement and would like us to bill your credit card immediately for any balances due after the processing of your insurance.

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