DR. GLENN I. GOLDBERG
BOARD CERTIFIED DERMATOLOGIST
COAST DERMATOLOGY AND LASER SURGERY CENTER

PATIENT INFORMATION *(Please Print)* Today's Date____/____/_____

Name____ SS#____________________
Last *First* *M.I.*

Mailing Address ____
Street # *City* *State* *Zip*

Date of Birth____/____/____ Age__________Sex ________Marital Status _________Drivers Lic # ______________

Home #_______________Work #__________________ Cell #______________Email ________________
Area Code *Area Code*

PARENT OR RESPONSIBLE PARTY

Name ____Date Of Birth ____/____/_____ Age __________
Last *First* *M.I.*

Address ____
City *State* *Zip*

Home Phone ______________________Work Phone __________________ SS# ____________________
Area Code *Area Code*

INSURANCE INFORMATION REQUIRED: Copy of insurance card and ALL information must be completed below

Primary Insurance ____________________________ Name Ins. Address ____________________________

Name of Insured ____________________________ DOB ____________SS# ____________________

Insured's ID# ____________________________ Group# ____________________________

Employer Name ____________________________ Employer Phone # ____________________________

Employer Address ____________________________ Relationship of patient to the insured ______________

Pharmacy of Choice ____ Phone______________

In case of Emergency__________________ Relationship ______________________ Phone______________

Referred By:__________________________/Other family members that are patients ______________________

Do We Have Your Permission To:

Leave a message on your answering machine at home? ❑ YES ❑ NO
Leave a message at your place of employment? ❑ YES ❑ NO
Discuss your medical condition with any other member of your household? ❑ YES ❑ NO

If yes, whom: ____________________________Relationship ____________________________

I authorize the release of medical information to my primary care of referring physician, to consultants if needed and as necessary to process insurance claims, insurance application and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature ____Date____/____/_____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. Applicable copayments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. You will be asked to pay any unmet deductible, non-covered services and copayments. In the event that your account must be turned over to collections, a $25.00 or 25% (whichever is greater) collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature ____Date____/____/_____

❑ **Copy of insurance card (both sides) attached.** **Updated By:** ____________________________

Coast Dermatology & Laser Surgery Center

Medical Questionnaire

Name:______________________________

Select any of the follow medical conditions that you currently have:

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

Have you had surgery on any of the following organs?

- ☐ Appendix
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Right – Left –Both)
- ☐ Breast: Mastectomy (Right – Left – Both)
- ☐ Colon (Colectomy) : Colon Cancer Resection
- ☐ Colon (Colectomy) : Diverticulitus
- ☐ Colon (Colectomy) : Inflammatory Bowel Disease
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart : Biological Valve Replacement
- ☐ Heart : Coronary Artery Bypass
- ☐ Heart : Heart Transplant
- ☐ Heart : Mechanical Valve Replacement
- ☐ Heart : PTCA
- ☐ Joint Replacement : Hip (Left – Right – Both)
- ☐ Joint Replacement : Knee (Left – Right – Both)
- ☐ Kidney : Biopsy
- ☐ Kidney : Stone Removal
- ☐ Kidney : Transplant
- ☐ Kidney : Nephrectomy
- ☐ Liver : Hepatectomy
- ☐ Liver : Transplant
- ☐ Liver: Shunt
- ☐ Ovaries (Oophorectomy) : Endometriosis
- ☐ Ovaries (Oophorectomy) : Ovarian Cancer
- ☐ Ovaries (Oophorectomy) : Cyst
- ☐ Ovaries : Tubal Ligation
- ☐ Pancreas : Pancreatectomy
- ☐ Prostate (Prostatectomy) : Biopsy
- ☐ Prostate (Prostatectomy) : Cancer
- ☐ Prostate (Prostatectomy) : TURP
- ☐ Rectum : APR
- ☐ Rectum : Low Anterior Resection
- ☐ Skin : Skin Biopsy
- ☐ Skin : Melanoma
- ☐ Skin : Basal Cell Carcinoma
- ☐ Skin : Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy) : Fibroids
- ☐ Uterus (Hysterectomy) : Uterine Cancer
- ☐ Uterus (Hysterectomy) : Cervical Cancer

Have you had any of the following skin conditions?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sun Burns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Other______________________________
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever / Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer

SEE OTHER SIDE

Coast Dermatology & Laser Surgery Center

Do you wear Sunscreen?

- ☐ Yes
- ☐ No

If yes, What SPF?__________

Do you tan in a tanning salon?

- ☐ Yes
- ☐ No

Do you have a family history of Melanoma?

- ☐ **Yes**
- ☐ **No**

If yes, which relative?

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter
- ☐ Other____________________________

Please list all current medications:____
____
____

Pharmacy & Location:____ **Phone#:**________________________

Please list all drug allergies: ____

- ☐ None

Social History:

- ☐ Not sexually active
- ☐ Sexually active with one partner
- ☐ Sexually active with more than one partner
- ☐ Same sex partner
- ☐ Drug use
- ☐ IV drug use

Ethnicity/Race:____________________________
____

Please check all that apply:

- ☐ Currently smokes – daily
- ☐ Currently smokes – not daily
- ☐ Former smoker
- ☐ Never smoker

- ☐ Drinks alcohol – Daily
- ☐ Drinks alcohol – Weekly
- ☐ Drinks alcohol – Never

How Did You Hear About Our Office?____

Dr. Glenn I. Goldberg

COAST DERMATOLOGY &
LASER SURGERY CENTER

Patient Name ______________________ Date ____________

PREFERRED PROVIDER AGREEMENT

Dear Patient:

You have arranged to be seen under an insurance contract agreement between our doctor and your insurance company.

We will bill your medical services directly to your insurance carrier for the full amount of the service. Following receipt of payment on the claim from your insurance carrier, any unmet deductibles, services not covered or excluded from your plan, or co-payments not paid at the time of service will be your sole responsibility. You are expected to pay this portion within 30 days of receipt of the payment from the Insurance company.

Although we are preferred providers under your insurance plan, this does not limit your liability. We are not obligated to wait for insurance reimbursement past 45 days after we have billed your insurance carrier. If no payment has been received from your insurance carrier past 45 days from the date billed, the balance becomes due and payable by you.

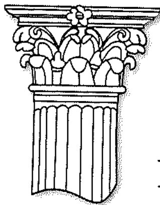
Medical services are being rendered to you. It is your obligation to understand and manage the provision of benefits by your insurance plan.

By signing this, you are acknowledging your responsibility under the terms of your insurance contract and your financial liability for medical services rendered to you at this office.

Insured's Signature or Representative ______________________ Date ____________

Witness / Office Representative ______________________ Date ____________

Coast Dermatology
&
Laser Surgery Center



Glenn I. Goldberg D.O.
Farah "Bobby" Awadalla, M.D.
Board Certified Dermatologists

PATIENT CARE SURVEY

The purpose of this survey is to educate and better serve your skin care needs.

1. Do you currently have a skin care program?

   ( ) Yes or ( ) No

2. If yes, what does your skin care program consist of?

   Please list your skin care products. ______________________________

   ____

3. Are you interested in learning more about our rejuvenating skin care program?

   ( ) Yes or ( ) No

4. What areas of your appearance would you like to improve? Please indicate your interest by checking the boxes below. These are minimal to no down time procedures.

   ( ) Brown Spots for hands & face neck & face

   ( ) Facial Veins

   ( ) Leg Veins

   ( ) Fractional C02 Laser for rejuvenation of facial wrinkles and skin tightening, pore size reduction

   ( ) Hair Removal for excess hair

   ( ) Botox, Dysport, and Xeomin for wrinkle lines around the eyes & forehead

   ( ) Fillers (Restylane, Juvederm, Belotero) for smile lines & lip enhancement

   ( ) Intense pulse light treatment for sun damage & smoother skin tone

   ( ) Volumizers (Radiesse, Sculptra, Voluma) for hollow cheeks, facial contour

   ( ) Fuller, longer, thicker eyelashes

31852 Coast Highway • Suite 300 • Laguna Beach, CA 92651
Tel: 949/499-1389 • Fax: 949/499-5689
www.GlennGoldbergSkinDr.com