

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 or 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:

- |  |   |
|--|---|
| <input type="checkbox"/> Anxiety                                   | <input type="checkbox"/> Hearing Loss         |
| <input type="checkbox"/> Arthritis                                 | <input type="checkbox"/> Hepatitis            |
| <input type="checkbox"/> Asthma                                    | <input type="checkbox"/> Hypertension         |
| <input type="checkbox"/> Atrial Fibrillation (Irregular Heartbeat) | <input type="checkbox"/> HIV / AIDS           |
| <input type="checkbox"/> BPH                                       | <input type="checkbox"/> Hypercholesterolemia |
| <input type="checkbox"/> Bone Marrow Transplantation               | <input type="checkbox"/> Hyperthyroidism      |
| <input type="checkbox"/> Breast Cancer                             | <input type="checkbox"/> Hypothyroidism       |
| <input type="checkbox"/> Colon Cancer                              | <input type="checkbox"/> Leukemia             |
| <input type="checkbox"/> COPD                                      | <input type="checkbox"/> Lung Cancer          |
| <input type="checkbox"/> Coronary Artery Disease                   | <input type="checkbox"/> Lymphoma             |
| <input type="checkbox"/> Depression                                | <input type="checkbox"/> Prostate Cancer      |
| <input type="checkbox"/> Diabetes                                  | <input type="checkbox"/> Radiation Treatment  |
| <input type="checkbox"/> End Stage Renal Disease                   | <input type="checkbox"/> Seizures             |
| <input type="checkbox"/> GERD                                      | <input type="checkbox"/> Stroke               |
| <br>   |   |
| <input type="checkbox"/> Other _____                               |   |

Have you had surgery on any of the following organs?

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

Have you had any of the following skin conditions?

- |   |  |
|---|--|
| <input type="checkbox"/> Acne                   | <input type="checkbox"/> Flaking or Itchy Scalp    |
| <input type="checkbox"/> Actinic Keratoses      | <input type="checkbox"/> Hay Fever / Allergies     |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Melanoma                  |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Poison Ivy                |
| <input type="checkbox"/> Blistering Sun Burns   | <input type="checkbox"/> Precancerous Moles        |
| <input type="checkbox"/> Dry Skin               | <input type="checkbox"/> Psoriasis                 |
| <input type="checkbox"/> Eczema                 | <input type="checkbox"/> Squamous Cell Skin Cancer |
| <br>  |  |
| <input type="checkbox"/> Other _____            |  |

**SEE OTHER SIDE**

Coast Dermatology & Laser Surgery Center

Do you wear Sunscreen?

- Yes
- No

Do you tan in a tanning salon?

- Yes
- No

If yes, What SPF? \_\_\_\_\_

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? \_\_\_\_\_

# MONARCH HEALTHCARE

## ELIGIBILITY WAIVER

PATIENT NAME:	HEALTH PLAN:
ID NUMBER:	EFFECTIVE DATE:
PHYSICIAN NAME:	

The Patient or Patient's Legal Representative hereby certifies that he/she is eligible for health plan benefits coverage, and has chosen the above stated physician as the provider of his/her health care.

Furthermore, the Patient or Patient's Legal Representative understands that if he/she is found ineligible for coverage of plan benefits, he/she is financially responsible for all costs incurred during the delivery of health services, and agrees to pay these charges to the physician accordingly.

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*Signature of Patient or Guardian*

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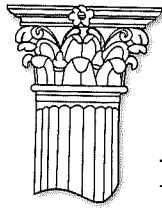
*Date*

---

*Witness*

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*Date*



## 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.

- |  |  |
|--|--|
| <input type="checkbox"/> Brown Spots for hands & face neck & face  | <input type="checkbox"/> Botox, Dysport, and Xeomin for wrinkle lines around the eyes & forehead   |
| <input type="checkbox"/> Facial Veins  | <input type="checkbox"/> Fillers (Restylane, Juvederm, Belotero) for smile lines & lip enhancement |
| <input type="checkbox"/> Leg Veins   | <input type="checkbox"/> Intense pulse light treatment for sun damage & smoother skin tone         |
| <input type="checkbox"/> Fractional CO2 Laser for rejuvenation of facial wrinkles and skin tightening, pore size reduction | <input type="checkbox"/> Volumizers (Radiesse, Sculptra, Voluma) for hollow cheeks, facial contour |
| <input type="checkbox"/> Hair Removal for excess hair  | <input type="checkbox"/> Fuller, longer, thicker eyelashes   |

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