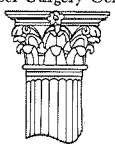
Coast Dermatology
&
Laser Surgery Center



Dr. Glenn I. Goldberg

Board Certified Dermatologist

MEDICARE PATIENT REGISTRATION

PLEASE PRINT

DATE_____

PATIENTS NAME_____
(FIRST) (MIDDLE INITIAL) (LAST)

ADDRESS_____
(# STREET) (CITY) (STATE) (ZIP)

DATE OF BIRTH_____ AGE_____ PATIENT'S SS#_____ DRIVER'S LICENSE_____

PHONE # _____ CELL PHONE _____ E-MAIL_____

MARITAL STATUS: (PLEASE CIRCLE) S M W D

MEDICARE # _____

SECONDARY INSURANCE COMPANY _____

POLICY NUMBER _____ GROUP NUMBER _____

SUBSCRIBERS NAME _____ DATE OF BIRTH _____ SS# _____

EMERGENCY CONTACT (Not living with you) _____ PHONE# _____

PATIENT'S EMPLOYER _____ BUSINESS PHONE # _____

DO WE HAVE YOUR PERMISSION TO: LEAVE A MESSAGE ON YOUR ANSWERING MACHINE? ❑ YES ❑ NO

ANSWER QUESTIONS BELOW BY PLACING A CHECK IN THE APPROPRIATE COLUMN:

YES	NO	
❑	❑	HAVE YOU RECENTLY JOINED A MEDICARE HMO? IF YES, IDENTIFY:_____
❑	❑	DO YOU OR YOUR SPOUSE WORK IN A COMPANY WHICH HAS MORE THAN 20 EMPLOYEES AND HAVE COVERAGE THROUGH THE INSURANCE AT THAT JOB?
❑	❑	ARE YOU COVERED BY A HMO/PPO WHICH MAKES MEDICARE SECONDARY?
❑	❑	IS THIS ILLNESS COVERED BY THE VA (VETERAN'S ADMINISTRATION)?
❑	❑	IS THIS ILLNESS COVERED BY THE FEDERAL BLACK LUNG OR END-STAGE RENAL DISEASE PROGRAM?

This office is required to keep your signature on file authorizing us to file claims to medicare for you and to release information to that payor if they require it for the proper consideration of a claim. please read and sign the following statement.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare 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. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____
Signature as it appears on Medicare Card Date

if you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over," we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any service furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Signature as it appears on Medigap Card Date

Thank you for choosing this office to assist in caring for your skin.

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
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke

☐ Other_____

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
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever / Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer

☐ Other_____

SEE OTHER SIDE

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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?_____

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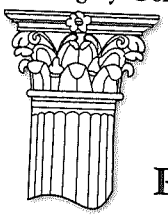

Glenn I. Goldberg D.O.
Farah "Bobby" Awadalla, M.D.
Board Certified Dermatologists

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

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

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

   ( ) I