Balfour Dermatology & Day Spa
A MEDICAL CORP.

WELCOME TO OUR OFFICE

2221 Balfour Road • Suite A • Brentwood, CA 94513
Bus: (925) 240-9116 • **Fax:** (925) 240-9117
www.skinquestion.com

Please assist us by accurately completing all information. Your information will remain strictly confidential and aid us in medical treatment and accurate filing of insurance. We offer insurance billing as a courtesy. You will be responsible for the deductibles, rules and regulations of your insurance.

PLEASE PROVIDE YOUR DRIVERS LICENSE AND INSURANCE CARD

Federal regulation requires a photo ID along with insurance card.

PATIENT INFORMATION:

Today's Date_____

Patient's Full Name_____ Marital Status ❒ S ❒ M ❒ W ❒ D

SSN #_____ Birthdate_____ Age_____ Sex ❒ Male ❒ Female E-mail_____

Street Address_____ City_____ State_____ Zip Code_____

Patient's Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Employer_____ Employer Address_____ Occupation_____

MEDICAL INFORMATION:

Family Doctor_____ Last Visit_____

Referring Doctor_____ Last Visit_____

Preferred Pharmacy_____ Location_____

EMERGENCY CONTACT INFORMATION:

Name_____ Phone (____) _____ Alternative Phone (____) _____

Relationship_____

FINANCIAL RESPONSIBILITY:

❒ Please process insurance claims on my behalf. I understand that I am responsible for all charges regardless of my insurance coverage.

❒ I will pay privately at each visit.

INSURANCE: *Information needed to process your claim.*

❒ **CO-PAY $**_____ (if not stated on card)

Insured (Subscriber)_____ Insured's Date of Birth_____

Insured's Relationship to Patient_____ Insured's Social Security _____
(some insurances require SS#)

Complete below ONLY if Patient is a Minor:

Who is responsible for account : ❒ Father ❒ Mother ❒ Other_____

❒ **Address+Phone same as above** (continue next form)

Address+Phone Different (Please complete below)

Father's Name_____ DOB_____

Father's Address_____

Father's Employer_____

Home Ph.(____)_____ Work Ph.(____)_____

❒ **Address+Phone same as above** (continue next form)

Address+Phone Different (Please complete below)

Mother's Name_____ DOB_____

Mother's Address_____

Mother's Employer_____

Home Ph.(____)_____ Work Ph.(____)_____

Balfour Dermatology

HIPAA - FINANCIAL – OFFICE POLICY

We appreciate your confidence in choosing our office. Please take a moment to review and acknowledge our office policies.

Privacy: We offer you a copy of a detailed privacy policy in our lobby. You may take a copy home or read the detailed policy prior to your visit. We use an outside billing service and pathology service. Your medical information will be shared with both outside sources to obtain the best service possible for your treatments.

Insurance: As a courtesy to our patients, Balfour Dermatology will bill your insurance. Balfour Dermatology uses a Sacramento billing office to process claims. I authorized the release of any information necessary to expedite my insurance claims. I understand that I am fully responsible for all charges regardless of insurance coverage.

Appointment Fees: All cancellations require a 24 hour notice. Failure to keep appointments and same-day cancellations/reschedules will result in a $25-$75 fee. Regular appointment fee is $25. Extended appointments; such as, Total Body Exam, Spa or any appointment for 45 minutes or longer, the fee is $75.00.

Co-payments: A co-payment is required each time you are seen. We require payment prior to your visit. We accept Visa, MasterCard, American Express, cash or personal check. If you do not have payment, we add a $10.00 processing fee to invoice your co-payment.

NSF Checks: We charge a $50.00 fee for any check returned from your bank for non-sufficient funds. We require all future payments are either cash or credit card.

Annual Deductibles: In addition to your co-payment, some plans also have deductibles. In the event that there is a balance after your insurance has paid its portion, you are required to pay that amount. Please pay your bill promptly and keep us updated of any address changes. Our policy is to send all delinquent accounts to a collection agency.

No Insurance Card/Valid Referral: We require an insurance card and HMO referral. If we do not have your insurance card/referral, you have the choice to privately pay or reschedule.

Office Etiquette: Please be courteous and respectful to other patients and our staff. We reserve the right to refuse service to anyone. You are encouraged to speak with our office manager if you have any concerns or praises.

I acknowledge that I have read and understand the policies of Balfour Dermatology. I understand that I have the right to refuse to sign this document.

Signature: _____ Date: _____

(Patient or Guardian if Patient is a minor)

Balfour Dermatology & Day Spa
A MEDICAL CORP.

MEDICAL HISTORY

To help evaluate your present, past and future health concerns.
PLEASE COMPLETE THE FOLLOWING MEDICAL HISTORY FORM.

Name_____ Date_____

Age:_____ Sex: ❒ M ❒ F Referred By: ❒ self/friend ❒ Dr. (name)_____

Reason for today's visit:_____ ❒ Skin Cancer Monitoring CC

Symptoms of today's problem:_____ HPI

Skin areas involved:_____ LOCATION

How long has the problem been present?_____ DURATION

Was there any previous treatment? ❒ Yes ❒ No When?_____ Type?_____ TIMING

Was a biopsy done? ❒ No ❒ Yes ❒ biopsy done by referring Dr. ❒ Other_____CONTEXT

CHECK ALL THAT APPLY TO TODAY'S PROBLEM

SYMPTOMS: ❒ itching ❒ tingling ❒ pain ❒ bleeding ❒ infection ❒ other_____ **QUALITY:** ❒ Intense ❒ Intermittent

What medications, including creams have been prescribed for your condition?_____

_____MODIFYING FACTOR

Which of these are you currently using?_____

Which "over the counter" medications have you used?_____

Which of these are you currently using?_____

Which brand of bath soap are you currently using?_____

SYSTEM REVIEW: Check all that apply regarding your health and add any other important problems.

Allergies to Medication: ❒ none ❒ list:_____

Current Medications:_____

_____

_____

Skin
❒ abnormal scarring
❒ poor healing
❒ other skin disorders

Cardiovascular
❒ normal
❒ angina
❒ artificial heart valve
❒ pacemaker
❒ hypertension
❒ heart attack (when?)_____

Neurological
❒ normal
❒ stroke
❒ seizures
❒ other:_____

Hematologic/Lymphatic
❒ normal
❒ anemia
❒ bleeding problems
❒ enlarged lymph nodes

Respiratory
❒ normal
❒ asthma
❒ emphysema
❒ other lung problems

Psychiatric
❒ normal
❒ depression
❒ anxiety attacks
❒ other:_____

Constitutional Symptoms
❒ none
❒ weight loss
❒ fever
❒ other:_____

Gastrointestinal
❒ normal
❒ stomach ulcer
❒ colitis
❒ liver damage
❒ other GI problems:_____

Endocrine
❒ normal
❒ diabetes
❒ thyroid
❒ kidney disease_____

Eyes/Ears/Nose/Throat
❒ normal
❒ glaucoma
❒ hearing aid
❒ plastic surgery

Musculoskeletal
❒ normal
❒ arthritis
❒ artificial joint
❒ other:_____

Infections
❒ none
❒ hepatitis
❒ HIV/AIDS
❒ tuberculosis (T.B.)
❒ other:_____

PAST HISTORY

Previous Skin Cancer: ❒ none ❒ list location(s):_____

Major illnesses or Hospitalizations:_____

_____

FAMILY HISTORY

Skin Cancer: ❒ none ❒ melanoma ❒ basal cell ❒ squamous cell ❒ List:_____

SOCIAL HISTORY

Occupation:_____ Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widow

Previous sunlight exposure or sunburns: ❒ mild ❒ moderate ❒ extensive ❒ tanning bed use ***Do you wear?:*** ❒ dentures ❒ glasses ❒ contact lenses

Do you Smoke?: ❒ no ❒ former ❒ yes, packs per day_____ ***Alcohol:*** ❒ no ❒ social/occasional drinking only

Alcohol or drug problems/addictions: ❒ no ❒ yes, describe:_____

Reviewed:

Patient Name: _____ **Date:** _____

Balfour Dermatology & Day Spa, Inc.

Please indicate if you are interested in learning more:

Botox or Dysport *(wrinkle relaxer)* _____

Juvederm/Restylane/Sculptra _____
(wrinkle filler & cosmetic facial enhancement)

MicroDermabrasion *(skin improvement)* _____

Chemical Peel *(skin improvement & lightening)* _____

Hair Removal *(laser)* _____

Facial Redness Reduction *(laser)* _____

Facial or Leg Vein Reduction _____
(laser or sclerotherapy)

Photo Facial / Dr Beer's Laser Peel _____

Skin Tightening *(laser)* _____

Excessive Underarm Sweating _____
(may be covered by insurance)

One of our staff will be happy to answer any questions.

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Enjoy Unadvertized Specials and New Products

NAME: _____

EMAIL ADDRESS: _____
(please write legibly)