



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 same as above (continue next form)

Address+Phone Different (Please complete below)

Address+Phone Different (Please complete below)

Father's Name _____ DOB _____

Mother's Name _____ DOB _____

Father's Address _____

Mother's Address _____

Father's Employer _____

Mother's Employer _____

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

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

Balfour Dermatology

HIPAA - FINANCIAL – OFFICE POLICY

We appreciate your confidence in choosing our office.

Privacy: We share your medical information with Delta Medical Billing, UCSF, Pathlogic and other professional agencies to obtain the best service possible for you. You may waive your right to privacy and authorize our office to give any and all medical information to a person(s) you designate below; including all diagnosis, HIV, lab/pathology results, billing/insurance questions, medications, plus any other information not specified.

AUTHORIZED to receive ALL medical information: _____
Your Designee or "None"

Insurance: As a courtesy to our patients, Balfour Dermatology will bill your insurance. We utilize a separate billing service, **Delta Medical Billing**, to process claims on your behalf. We try our best, but due to ever changing insurance policies we do not offer any guarantee of payment or coverage. You are fully responsible for all charges regardless of your insurance's coverage.

Co-payments/Coinsurance/Annual Deductibles: You are responsible for your co-insurance, out-of-network portion and/or annual deductible at time of service.

Checks: We cannot accept a check for over \$100. Return check fees are \$50.

Cancellation Fees: CANCELLATIONS REQUIRE 24 HR NOTICE, to avoid FEE \$75

RX Refills: PLEASE CALL YOUR PHARMACY. If it's been over a year since we've seen you; please call us for an appointment.

RX Prior Authorizations: We will be happy to transfer your RX to a pharmacy that will manage this time consuming process.

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, but the office policies still apply. Please let us know if you'd like a copy of this for your records.

Your Signature: _____ Date: _____
(Patient or Guardian for Minor)



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: _____

DO YOU HAVE ANY COSMETIC SKIN CONCERNS?

Do you want to learn more about the best practices for caring for your skin?

Circle Any that Apply

- ✱ Learn about **Basic Skin Care**? YES
- ✱ Learn about **Anti-Aging & Wrinkle** treatments? YES
- ✱ Learn about removing **Brown Spots & Sun Damage**? YES
- ✱ Get Information on **Hair Removal**? YES
- ✱ Learn about **Acne Scarring** treatments? YES
- ✱ Investigate non-medical **Acne** treatments? YES
- ✱ Learn about **Skin Tags**? YES
- ✱ Learn about **Excessive Sweating** treatments? YES
- ✱ Get information on **Botox**? YES
- ✱ Learn about **Chemical Peels** and **Microderms**? YES
- ✱ Need info on **Reducing Redness** or **Unsightly Veins**? YES



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Facebook

Balfour Dermatology

Show any staff member that you've liked us on Facebook for a Free sample product.

If you prefer monthly emails on our Special Offers please provide your email address.

your e-mail

your name

For additional discounts on Botox, Skincare, Juvederm & Voluma

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