



SKIN & BEAUTY CENTER
COSMETIC, MEDICAL & SURGICAL DERMATOLOGY
DermLA.com

Burbank
191 S. Buena Vista St. Suite 475
Burbank, CA 91505
T: (818) 842-8000
F: (818) 842-3208

Northridge
9535 Reseda Blvd. Suite 304
Northridge, CA 91324
T: (818) 886-3884
F: (818) 886-5418

Santa Clarita
23501 Cinema Drive, Suite 111
Valencia, CA 91355
T: (661) 258-3811
F: (323) 935-8804

Glendale
1818 Verdugo Blvd., Suite 304
Glendale, CA 91208
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Registration Form

ACCT #: _____

PATIENT INFORMATION:

Name (First, Middle, Last): _____ Date of Birth: _____

Name of Person Legally Responsible: _____

Sex: Male Female Social Security #: _____ Driver's License #: _____

Marital Status: Single Married Divorced Widow Primary Language _____

Race: African American American Indian or Alaska Native Asian Native Hawaiian or other Pacific Islander
 White Unknown Other _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Provide your email to receive exclusive specials and news: **Email Address:** _____

Home Address: _____ Telephone #: _____

City, State, and Zip Code: _____ Alternate Tel. #: _____

Employer: _____ Occupation: _____

Work Address: _____ Work Telephone #: _____

City, State, and Zip Code: _____

Spouse Name: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

PHARMACY INFORMATION:

Pharmacy Name: _____

Address: _____ Telephone #: _____

City, State, and Zip Code: _____

If you do not have a preferred pharmacy, below are close-by pharmacies for your convenience:

- DNM Pharmacy, 6221 Wilshire Blvd. #100, Los Angeles, CA 90048, Phone: (323) 634-8930
- Burbank Compounding Pharmacy, 201 S. Buena Vista St. #110, Burbank, CA 91505, Phone: (818) 563-2120

INSURANCE INFORMATION:

PRIMARY INSURANCE:

Insurance Company: _____ Policy #: _____ Group #: _____

Insured's Name (First, Middle, Last): _____ Date of Birth: _____

Social Security #: _____ Relationship to Patient: _____

SECONDARY INSURANCE:

Insurance Company: _____ Policy #: _____ Group #: _____

Insured's Name (First, Middle, Last): _____ Date of Birth: _____

Social Security #: _____ Relationship to Patient: _____

TERTIARY INSURANCE:

Insurance Company: _____ Policy #: _____ Group #: _____

Insured's Name (First, Middle, Last): _____ Date of Birth: _____

Social Security #: _____ Relationship to Patient: _____

By my signature below, I authorize payment of medical benefits to Skin and Beauty Center, Inc. for services provided. This authorization is valid until revoked in writing. State Law AB 1236 makes it mandatory rather than permissive that insurance companies honor assignment of benefits. I authorize release of any medical information necessary to process claims submitted on my behalf or on the behalf of my children.

Signature: _____ Date: _____

Medical History Form

Name: _____ Date: _____ Age: _____ Sex: Male Female

Referred by: Self Dermla.com ZocDoc www.skinclinicla.com Google Yelp Insurance Co.'s website

Online Directory _____ Friend _____ Other _____

Dr. _____ Address: _____ Phone: _____

Who is your primary medical doctor: _____ City: _____ Phone: _____

Reason for today's visit: _____

Current Medications (include all over the counter products/vitamins): None

Medications Allergies: No known medication allergies

Medical History and Review of Systems: Current or Past Problems with: None

<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Lung/Respiratory Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Arthritis/Joints/Muscles	<input type="checkbox"/> Herpes	<input type="checkbox"/> Prostate problems	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Anemia/Hematologic	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Anticoagulation
<input type="checkbox"/> Irregular menses	<input type="checkbox"/> STDs/Chlamydia/Gonorrhea	<input type="checkbox"/> Seizures	<input type="checkbox"/> Genital Lesions	<input type="checkbox"/> Hepatitis /Liver Disease
<input type="checkbox"/> Kidney Dz/Stones	<input type="checkbox"/> Allergies (non-drug)/Hay Fever	<input type="checkbox"/> Eye/Vision	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Organ Transplant
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Depression /Psychiatric Dz	<input type="checkbox"/> Fever/Chills	<input type="checkbox"/> Gastrointestinal Dz	<input type="checkbox"/> Pacemaker/Defibrillator
<input type="checkbox"/> Weight Change	<input type="checkbox"/> Neurologic/Headaches	<input type="checkbox"/> Endocrine	<input type="checkbox"/> Artificial joint	<input type="checkbox"/> Heart Valve

Others, please explain: _____

Females: **Pregnant?** Yes No // Planning to become pregnant? Yes No // On birth control? Yes No

Brest Feeding? Yes No

Skin Problems: Current or Past Problems with: None

<input type="checkbox"/> Eczema	<input type="checkbox"/> Abnormal Moles	<input type="checkbox"/> Hives	<input type="checkbox"/> Recent or Progressive Hair Loss	<input type="checkbox"/> Frequent sun exposure	<input type="checkbox"/> Trouble healing/Keloids
<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Excessive Scarring	<input type="checkbox"/> Rash	<input type="checkbox"/> Precancerous Spots (actinic keratosis)	<input type="checkbox"/> Acne	<input type="checkbox"/> Tanning
<input type="checkbox"/> Non Melanoma Skin cancer: site(s), Year(s):			<input type="checkbox"/> Melanoma: site, stage, Year:		<input type="checkbox"/> Oint/Tape allergy

Others, please explain: _____

Family History: None

<input type="checkbox"/> Melanoma who: _____	<input type="checkbox"/> Eczema	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Skin Cancer who: _____	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Cancer (Non skin)	<input type="checkbox"/> Heart Disease

Others, please explain: _____

Social History:

Occupation: _____ Marital Status: Single Married Divorced Widow

Smoking? Yes No Former // Alcohol? Yes No Former // Drugs? Yes No Former

We offer a full range of Cosmetic procedures. These procedures are not covered by Insurance. Please check any of the following procedures that you would like to discuss with our doctors.

<input type="checkbox"/> Botox / Dysport	<input type="checkbox"/> Keratotic Growth Removal	<input type="checkbox"/> Chemical Peels for Skin Pigmentation/Melasma
<input type="checkbox"/> Skin Tag Removal	<input type="checkbox"/> Age Spots on Hands, Arms, Chest	<input type="checkbox"/> Restylane or Radiesse (filler for wrinkles)
<input type="checkbox"/> Earlobe Repair	<input type="checkbox"/> Anti-Aging Skincare products	<input type="checkbox"/> Sclerotherapy for Leg Veins
<input type="checkbox"/> Lip Augmentation	<input type="checkbox"/> Facials for Men and Women	

(Office Use Only) Confirmed by: _____

Patient Consent, Authorization and Acknowledgement

This form is to inform you of your rights and responsibilities as a patient.

Initial

1. **Consent to Treatment:** I hereby authorize Skin and Beauty Center (SBC), Inc. to provide medical services to me, and I hereby consent to the performance of laboratory tests, diagnostics, and other medical treatment as discussed with my physician. _____
2. **Release of Information:** I understand that SBC may release and disclose all or portions of my payment record for treatment, payment or health care operations in accordance with federal and state law. I hereby authorize SBC to make such disclosures to any person or entity which is or may be responsible for all or part of the charges for services rendered to me (including, but not limited to, insurers, employers, health care plans, welfare funds and workers compensation carriers) for the purposes of obtaining payment, and to other health care providers for diagnosis or treatment. I understand that special permission is needed to release HIV test results, treatment information regarding drug or alcohol abuse and certain mental health records. _____
3. **Photography:** With the understanding that great care will be taken not to reveal identity, I consent to the taking of photographs/videos before, during and after a medical procedure, as well as for any and all related medical procedures. These photographs/videos will be the property of SBC and/or its assignees, and may be used for medical, scientific, teaching, publication or promotional purposes. _____
4. **Assignment of Benefits:** I hereby assign SBC and authorize payment directly to it, of any and all health insurance or health plan benefits (including Medicare) otherwise payable on my behalf or to me for services rendered. _____
5. **Financial Agreement:** It is your responsibility to check with your insurance carrier about your eligibility and coverage prior to being seen in this clinic. In addition, we will make every attempt to bill your insurance company on your behalf, however, you will assume responsibility for any unpaid portion of the services provided. By signing below, you agree that you are financially responsible for services rendered to you in accordance with the regular rates and terms of SBC. You understand and agree that any charges not paid by health plan or insurance benefits or otherwise not covered by your health insurance (including, but not limited to, co-payments, coinsurance, and deductibles) are your financial responsibility. All accounts are due and payable upon presentation of a statement. Also, you agree that SBC contracts with various health care plans, Medical Groups and Independent Physician Associations. If services rendered are found to be non-covered or non authorized by your health insurance, or if you are not eligible to receive services, you agree to be individually obligated to pay the full cost of the services rendered to you by SBC. _____
6. **Cosmetic Procedures:** We do not bill insurance carriers for cosmetic procedures (lasers, peels, sclerotherapy, fillers, Botox®, etc). All cosmetic procedures must be paid in full prior to the procedure. _____
7. **Consent to biopsy:** Occasionally, your provider might recommend a skin biopsy. By signing below you are consenting to this procedure while a patient of this clinic. The risks of a skin biopsy are minimal, and include discoloration and scarring. **The pathology service will bill you directly, distinct and separate from the fee charged by the physician for performing the biopsy.** _____
8. **Ancillary Services:** I understand that services may be furnished by other providers (such as laboratory). I understand that I will be billed separately by the provider furnishing the services and I understand that I am financially responsible for the bill from these providers. _____
9. **Guarantee:** While a procedure is effective in most cases, no guarantee can be made that a specific patient will benefit from a procedure. No guarantee or assurance, either verbal or in writing, will be given by anyone about the results of any procedure performed in this clinic. _____
10. **Copays and Deductible:** I understand that all copay and deductible amounts are collected in advance of the visit and/or procedure. It is my responsibility to verify coverage and eligibility for services and procedures prior to seeking treatment. _____
11. **Right to refuse service:** You and the clinic have the right to refuse treatment at anytime for any reason. _____
12. **Privacy Notice Acknowledgement:** I hereby acknowledge that I am entitled to receive a copy of SBC's Notice of Privacy Practices. _____
13. **Duration:** This Consent will be effective as long as you are a patient of this clinic. _____

I hereby certify that I have read, understand, and accept the above terms and conditions. I further certify that I am the patient or the patient's legal representative and am authorized to sign this document. I understand that I have a right to receive a copy of this

Patient Name (print)	Patient/Parent Signature	Date
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