SKIN & BEAUTY CENTER
Cosmetic, Medical and Surgical Dermatology
DermLA.com

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

SANTA CLARITA
27879 Smyth Drive
Valencia, CA 91355
T: (877) 822-2223
F: (323) 935-8804

NDA
NORTHRIDGE DERMATOLOGY ASSOCIATES

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

William R. Coleman, MD
David H. Friedman, MD
Ava Khosraviani, MD
Pranita V. Rambhatla, MD
Payam Saadat, MD
Manjunath S. Vadmal, MD
Kristen Ochsner, PA-C
Jenna Trubschenck, PA-C

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: _____

SKIN & BEAUTY CENTER
Cosmetic, Medical and Surgical Dermatology
DermLA.com

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

SANTA CLARITA
27879 Smyth Drive
Valencia, CA 91355
T: (877) 822-2223
F: (323) 935-8804

NDA
NORTHRIDGE DERMATOLOGY ASSOCIATES

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

William R. Coleman, MD
David H. Friedman, MD
Ava Khosraviani, MD
Pranita V. Rambhatla, MD
Payam Saadat, MD
Manjunath S. Vadmal, MD
Kristen Ochsner, PA-C
Jenna Trubschenck, PA-C

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

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

Others, please explain: _____

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

Skin Problems: Current or Past Problems with: □ None

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

□ Others, please explain: _____

Family History: □ None

□ Melanoma who:_____	□ Eczema	□ Hay Fever	□ Psoriasis	□ Diabetes
□ Skin Cancer who:_____	□ Asthma	□ Hair Loss	□ Cancer (Non skin)	□ 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.

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

(Office Use Only) Confirmed by: _____

When filling out on the computer, please be sure to properly save the form after completing.
YOU SHOULD OPEN THE FILE AFTER SAVING TO ENSURE YOUR INFORMATION WAS PROPERLY SAVED (MAKE SURE IT IS NOT BLANK!).
After confirming, please email the forms to FrontOffice@DermLA.com. Thank you.

SBC
SKIN & BEAUTY CENTER
Cosmetic, Medical and Surgical Dermatology
DermLA.com

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

SANTA CLARITA
27879 Smyth Drive
Valencia, CA 91355
T: (877) 822-2223
F: (323) 935-8804

NDA
NORTHRIDGE DERMATOLOGY ASSOCIATES

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

William R. Coleman, MD
David H. Friedman, MD
Ava Khosraviani, MD
Pranita V. Rambhatla, MD
Payam Saadat, MD
Manjunath S. Vadmal, MD
Kristen Ochsner, PA-C
Jenna Trubschenck, PA-C

Patient Consent, Authorization and Acknowledgement

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

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. **Right to refuse service:** You and the clinic have the right to refuse treatment at anytime for any reason.
11. **Privacy Notice Acknowledgement:** I hereby acknowledge that I am entitled to receive a copy of SBC's Notice of Privacy Practices.
12. **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 document.

_____	_____	_____
Signature – Patient/Legal Guardian	Print Name/Relationship	Date

This page can be filled-out and signed when you arrive for your appointment.