

Referred by: ____

Employer: _

Spouse name:

Phone: _

Name:

Phone: _

Name:_

Employer: _

Address: ____

City

Phone:

Date of birth:

Last

Emergency Contact Information

Cell

Last

Cell

Insurance Information

Last

Cell

Advanced Dermatology of Orange County 230 Newport Center Drive Suite 200 Newport Beach, CA 92660 (949) 706-7766 Fax (949) 706-2211

Name:		
Last	First	MI
Preferred name:		
Date of birth:	Age:	Male Femal
Address:		
City	State	Zip code
Phone:		
Home	Cell	
E	Email:	
Work		
Best place to leave me	essages, including co	onfidential
information (Note: cell	phones are not necess	
messages will be left wit	h your permission).	

Occupations: _____

Marital status Single Married Divorced Widowed

First

Insured person is 🔲 Patient 🔲 Spouse 🔲 Parent 🔲 Other

First

Age: _

First

MI

MI

Zip code

☐ Male ☐ Female

Work

Work

State

Work

Medical History: Current Medical Problems

Are you pregnant or nursing? Consent for care, treatment, and financial responsibile I consent to examination and treatment, including biopsile local surgery, and other procedures deemed necessary, af discussion of the risks and benefits of these treatments are procedures with my physician. I hereby assign all medicale benefits to which I am entitled to Advanced Dermatolog Orange County, Inc. I understand that I am financially responsible for all charges incurred, including cost that m insurance company does not pay for. I authorize the relear any necessary medical information to my insurance carried process my claim. Bignature Date Pharmacy Information	 History of fainting or near fainting Cardiac Pacemaker, Artificial Heart Valve HIV or AIDS History of exposure to hepatitis B or C Are you pregnant or nursing? Consent for care, treatment, and financial responsibil I consent to examination and treatment, including biopsilocal surgery, and other procedures deemed necessary, aff discussion of the risks and benefits of these treatments and procedures with my physician. I hereby assign all medical benefits to which I am entitled to Advanced Dermatolog Orange County, Inc. I understand that I am financially responsible for all charges incurred, including cost that main insurance company does not pay for. I authorize the releat any necessary medical information to my insurance carried process my claim. Signature Date 	Check if you have: Personal or Family history of Melanoma History of other skin cancer (basal cell, squamous cell carcin History of fainting or near fainting Cardiac Pacemaker, Artificial Heart Valve HIV or AIDS History of exposure to hepatitis B or C Are you pregnant or nursing? Consent for care, treatment, and financial responsible I consent to examination and treatment, including biopsi local surgery, and other procedures deemed necessary, af discussion of the risks and benefits of these treatments as procedures with my physician. I hereby assign all medical benefits to which I am entitled to Advanced Dermatolog Orange County, Inc. I understand that I am financially responsible for all charges incurred, including cost that m insurance company does not pay for. I authorize the relea any necessary medical information to my insurance carrie process my claim. Signature Date Pharmacy Information Pharmacy	Drug Allergies Check if you have: Personal or Family history of Melanoma History of other skin cancer (basal cell, squamous cell carcin History of fainting or near fainting Cardiac Pacemaker, Artificial Heart Valve HIV or AIDS History of exposure to hepatitis B or C Are you pregnant or nursing? Consent for care, treatment, and financial responsible I consent to examination and treatment, including biopsis local surgery, and other procedures deemed necessary, aff discussion of the risks and benefits of these treatments ar procedures with my physician. I hereby assign all medical benefits to which I am entitled to Advanced Dermatolog Orange County, Inc. I understand that I am financially responsible for all charges incurred, including cost that m insurance company does not pay for. I authorize the relea any necessary medical information to my insurance carrie process my claim. Bignature Date Date Pharmacy Information	I consent to e local surgery, discussion of procedures wi benefits to wh Orange Coun responsible for insurance con any necessary process my cli Signatu Pharmacy Infe Pharmacy	and other procedures the risks and benefits ith my physician. I he nich I am entitled to a ty, Inc. I understand or all charges incurred npany does not pay for medical information aim.	s of these treatments ar ereby assign all medical Advanced Dermatolog that I am financially d, including cost that m or. I authorize the relea to my insurance carrie
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