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

Patient Information

Name:____
Last First MI

Preferred name: ____________________________________

Date of birth: ____________ Age: _______ ☐ Male ☐ Female

Address: ____

____
City State Zip code

Phone: ____
Home Cell

_________________ Email: __________________________
Work

Best place to leave messages, including confidential information (Note: cell phones are not necessarily confidential, but messages will be left with your permission).

____

Primary Medical Physician: __________________________

Referred by: _______________________________________

Occupations: _______________________________________

Employer: ____

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse name: _______________________________________
Last First

Phone: ____
Cell Work

Emergency Contact Information

Name:____
Last First MI

Phone: ____
Cell Work

Insurance Information

Insured person is ☐ Patient ☐ Spouse ☐ Parent ☐ Other

Name:____
Last First MI

Employer: ____

Address: ____

____
City State Zip code

Phone: ____
Cell Work

Date of birth: ____________ Age: _______ ☐ Male ☐ Female

Medical History:

Current Medical Problems

Previous Surgeries

Medications

Drug Allergies

Check if you have:

- ☐ Personal or Family history of Melanoma
- ☐ History of other skin cancer (basal cell, squamous cell carcinoma)
- ☐ 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 responsibility:

I consent to examination and treatment, including biopsies, local surgery, and other procedures deemed necessary, after 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 Dermatology of Orange County, Inc. I understand that I am financially responsible for all charges incurred, including cost that my insurance company does not pay for. I authorize the release of any necessary medical information to my insurance carrier to process my claim.

________________________________ ______________
Signature Date

Pharmacy Information

Pharmacy ____

Address (or cross streets) ___________________________

City ____________________ Phone ___________________