PAZ DERMATOLOGY

PATIENT REGISTRATION

Carlos Paz, MD, PhD
Melissa Manriques, FNP-C
Gabriel Zapata, PA-C
Clarissa Alvarado, FNP-C
Amal Muthana FNP-C
Joanne M. Gloria, PA-C

PATIENT INFORMATION:

Name (Last, First, MI): _____ ☐ Jr. ☐ Sr.

Date of Birth: _____ Sex: ☐ M ☐ F ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Address: _____

City: _____ State: ____ Zip: _____ Email Address: _____

Can we email you appointment reminders? ☐Yes ☐No

Cell Phone: _____ Can we text you appointment reminders? ☐Yes ☐No

Home Phone: _____ Patient's Social Security Number: _____

Primary Care Physician (PCP): _____

Address: _____ Phone: _____

How did you hear about our office? ☐ Doctor ☐ Insurance Plan ☐ Google ☐ Yelp ☐ Family/Friend ☐ Other, specify: _____

Primary Insurance: _____

Subscriber's Name: _____ Subscriber's Date of Birth (Required) _____

Subscriber's Social Security Number: _____

Subscriber ID: _____ Group #: _____ Policy #: _____

Employer Name: _____

Address: _____ Phone: _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other___

Secondary Insurance: _____

Subscriber Name: _____ Subscriber's Date of Birth (Required) _____

Subscriber's Social Security Number: _____

Subscriber ID: _____ Group #: _____ Policy #: _____

Employer Name: _____

Address: _____ Phone: _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

If under 18, mother/father's name: _____

Emergency Contact: _____

Relationship to Patient: _____ Phone: _____

Please identify and provide phone number for any individual(s) with whom our staff can discuss your medical condition or bills.

1. _____ ☐ Medical Information ☐ Billing Information

2. _____ ☐ Medical Information ☐ Billing Information

PAZ DERMATOLOGY

PATIENT REGISTRATION
Carlos Paz, MD, PhD
Melissa Manriques, FNP-C
Gabriel Zapata, PA-C
Clarissa Alvarado, FNP-C
Amal Muthana FNP-C
Joanne M. Gloria, PA-C

PHARMACY

Pharmacy Name and Address: _____

Pharmacy Phone Number: _____

DERMATOLOGY MEDICAL HISTORY

Reason for today's visit (chief complaint): _____

How long have you had this problem? _____

What parts of your body are affected? _____

How does this problem bother you (symptoms)? _____

What treatments have you received for this problem? _____

Is your problem? ☐ Worsening ☐ Stable ☐ Improving

Previous Dermatologist (if applicable): Name: _____

Address: _____ Phone: _____

Cosmetic Consultation: Our office offers a variety of cosmetic services including Botox, fillers, laser treatments, liposuction, and cosmetic surgery. Are you interested in learning more about these services during your office visit? ☐ Yes ☐ No

Alerts: (Check All that apply)

Women: Are you pregnant? ☐ Yes ☐ No Do you plan to become pregnant soon? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

☐ Allergy to lidocaine ☐ Artificial joints (past 2 years) ☐ Pacemaker ☐ Artificial topical antibiotic ointments

☐ Allergy to heart valve ☐ MRSA ☐ Premedication prior to procedures ☐ Blood thinners ☐ None

Any allergy to any other medication not listed above? ☐ Yes ☐ No If yes, please list: _____

PAST MEDICAL HISTORY

☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial fibrillation
☐ Bone Marrow Transplantation
☐ BPH (Benign Prostatic Hyperplasia)
☐ Breast Cancer
☐ Colon Cancer
☐ COPD (Emphysema)
☐ Coronary Artery Disease
☐ Depression
☐ Diabetes
☐ End Stage Renal Disease
☐ GERD (Acid reflux)
☐ Hearing Loss
☐ Hepatitis
☐ HIV/AIDS
☐ Prostate Cancer
☐ Radiation Treatment
☐ Seizures
☐ Stroke
☐ None
☐ Other: _____

List all medications you are currently taking (including prescriptions, over-the-counter meds, etc.)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

PAST SURGICAL HISTORY

☐ Appendix Removed
☐ Basal Cell Carcinoma Surgery
☐ Breast Biopsy
☐ Breast Implants
☐ Coronary Artery Bypass
☐ Gallbladder Removed

☐ Hysterectomy: Fibroids
☐ Hysterectomy: Uterine Cancer
☐ Joint Replacement (within last 2 years)
☐ Kidney Biopsy
☐ Kidney Transplant
☐ Lumpectomy ☐ ☐Left
☐ Mastectomy ☐ ☐Left
☐ Melanoma Surgery
☐ Prostate Biopsy
☐ Prostate Removed: Prostate Cancer
☐ Skin Biopsy
☐ Spleen Removed
☐ Squamous Cell Carcinoma Surgery
☐ None
☐ Other, specify: _____

SKIN DISEASE HISTORY: (Check all that apply)

☐ Appendix Removed
☐ Basal Cell Carcinoma Surgery
☐ Breast Biopsy
☐ Breast Implants
☐ Coronary Artery Bypass
☐ Gallbladder Removed
☐ Hysterectomy: Fibroids
☐ Hysterectomy: Uterine Cancer
☐ Joint Replacement (within last 2 years)
☐ Kidney Biopsy
☐ Kidney Transplant
☐ Lumpectomy ☐ ☐Left
☐ Mastectomy ☐ ☐Left
☐ Melanoma Surgery
☐ Prostate Biopsy
☐ Prostate Removed: Prostate Cancer
☐ Skin Biopsy
☐ Spleen Removed
☐ Squamous Cell Carcinoma Surgery
☐ None
☐ Other, specify: _____
☐ Abnormal Moles
☐ Actinic Keratoses
☐ Acne
☐ Eczema
☐ Flaking or Itchy Scalp
☐ Hayfever/Allergies
☐ Psoriasis
☐ Squamous Cell Carcinoma
☐ None
☐ Basal Cell Skin Carcinoma
☐ Melanoma
☐ Other, specify:
☐ Blistering Sunburns
☐ Poison Ivy
Do you wear sunscreen? ☐ Yes ☐ No
If yes, what SPF? _____
Do you tan in tanning salon? ☐ Yes ☐ No
Do you have a family history of Melanoma? ☐ Yes ☐ No If yes, which relative(s)? _____
Any other skin cancer family history?
☐ Yes ☐ No Specify: _____

SOCIAL HISTORY: (Check all that apply)

Cigarette Smoking:
☐ Never smoked
☐ Quit: former smoker
☐ Smokes less than daily
☐Smokes daily

*Please note: If you are a smoker CMS requires us to encourage you to stop smoking. ☐ Initial

Do you drink alcohol?
☐ Yes
☐ No

How often do you exercise?
☐ Once a day
☐ A few times a week
☐ Occasionally
☐ Never

What is your caffeine use?
☐ Once a day
☐ A few times a week
☐ A few times a month
☐ Never

Language:
☐ English
☐ Spanish
☐ Other: _____

Ethnicity:
☐ Hispanic/Latino
☐ Non-Hispanic/Latin

Race:
☐ White
☐ Black/African American
☐ American or Native Alaskan
☐ Native Hawaiian/Pacific Islander
☐ Asian

If needed, please elaborate on any of the above: _____

TREATMENT CONSENT

I hereby give consent for medical treatment to the providers with PAZ Dermatology to care for myself or I am duly authorized by the patient as his/her agent or guardian to give consent for such treatment.

Patient Signature (or signature by parent or guardian if patient is a minor) Date

CONSENT TO PHOTOGRAPH

This form is to be used only for photographs taken for treatment for PAZ Dermatology's own healthcare operations, as allowed under the federal privacy laws. Photography for other purposes (e.g., research, publication, outside education, marketing, public relations, news, or documentary) requires use of a separate form "consent to photograph and authorization for use and disclosure."

The undersigned hereby consents to be photographed while receiving treatment at the office, with the understanding that the images from such photography may be used for the patient's treatment or for the office healthcare operations, such as medical review, peer review, or medical education review, as the treating healthcare provider(s) deem appropriate. The term "photograph" as used herein includes video or still photography in digital or any other format, and any other means or recording or reproduction images.

Signature _____ Date _____

At Paz Dermatology, we are committed to providing high-quality, personalized dermatologic care. To ensure that we can accommodate the needs of all our patients in a timely and effective manner, we have implemented the following policies:

ARRIVAL TIME

Patients are expected to arrive 10–15 minutes before their scheduled appointment time to allow for check-in, insurance verification, and any necessary paperwork.

If you arrive on time but still need to complete paperwork, your appointment may be delayed or rescheduled to avoid impacting other patients' appointments.

New patients should arrive at least 15 minutes early to complete registration and medical history forms.

APPOINTMENT CANCELLATIONS

We kindly request at least 24 hours notice for any appointment cancellations or rescheduling. This allows us to offer the appointment time to another patient in need of care. Cancellations made less than 24 hours in advance may be subject to a cancellation fee of [$50–$150] depending on the appointment type.

- General derm: $50
- Cosmetic: $100
- Surgery: $150

If you are running late, please call our office. Patients who arrive 15 minutes or more past their scheduled time may be asked to reschedule.

NO-SHOW POLICY
A "no-show" is when a patient misses an appointment without calling to cancel or reschedule.
After one no-show, we will remind you of our policy. After two no-shows, a fee of [$50–$150] may be charged to your account. depending on the appointment type.

- General derm: $50
- Cosmetic: $100
- Surgery: $150

After three or more no-shows, we reserve the right to discharge you from our practice or require a deposit for future appointments.

FEE POLICY
Please note that cancellation and no-show fees are not covered by insurance and are the responsibility of the patient. We understand that emergencies and unforeseen circumstances arise. In such cases, we ask that you notify us as soon as possible so that we can make appropriate accommodations.
We appreciate your understanding and cooperation as we strive to provide the best care for all of our patients.

FINANCIAL AND BILLING POLICIES
I have read, understand, and agree to the financial billing policies can be found at the front desk or at our website (www.pazderm.com). I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles are patient responsibility.

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES
I have read, understand, and agree to the Notice of Privacy Practices. It is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy on our front desk or at our website (www.pazderm.com) and you may request a printed copy of the revised Notice of Privacy Practice from our office when applicable.

Signature _____ Date _____

"A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable."