

Dale Pearlman MD
Family Dermatology 

(Please Print)

Today's date:		Patient ID number:	
PATIENT INFORMATION			
Last name:		First:	Middle:
Social Security no.:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Birth date: / /	
Address:		City:	State: ZIP Code:
Employer:		Employer address:	
Home phone no.:	Work phone no.:	Cell phone no.:	
Referred to this office by:			

RESPONSIBLE PARTY IF PATIENT IS A CHILD		
Last name:		Middle:
Address:		Relationship to patient:
Phone no.:		

INSURANCE INFORMATION			
Primary insurance carrier:			
Do you have secondary insurance ?		Carrier's name:	
<input type="checkbox"/> Yes <input type="checkbox"/> No			
Please complete the following only if primary insurance is that of spouse, parent or other.			
Employer:	Work phone number:	Birth date: / /	Social Security #:
Relationship to patient:		Subscriber Name:	

IN CASE OF EMERGENCY			
Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS	
I authorize the release of any medical information necessary to process claims to my insurance companies. I request payment of authorized medical insurance benefits either to myself or to Dale Pearlman M.D. I authorize payments of assigned medical benefits to be paid directly to Dale Pearlman M. D. and I am responsible for deductibles, co-insurances and non-covered services.	
_____ <i>Patient/Guardian signature</i>	_____ <i>Date</i>

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Medical History (Page 1)

Name	Date	Age
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CURRENT MEDICAL PROBLEMS	CURRENT MEDICATIONS

Pacemaker: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Recent surgery (last three months?) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list:	
Prior surgery ever? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list:	
Allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list:	
Any prior serious illnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list with year of problem:	
Internal cancer:	Skin cancer:
Stroke:	Heart attack:
Other:	Other:
Sun exposure/tanning ever in your life? <input type="checkbox"/> Never <input type="checkbox"/> Mild <input type="checkbox"/> A lot	
Family history of any of the following?	
Hayfever <input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No
Eczema <input type="checkbox"/> Yes <input type="checkbox"/> No	Psoriasis <input type="checkbox"/> Yes <input type="checkbox"/> No
Skin cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	

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HIPAA Notice of Privacy Practices

Last Name

First Name

Middle Name

American physicians are now required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to provide you with a written "Notice of Privacy Practices". This describes how our office may use medical information about you or your child: who may use it, how it may be disclosed, and how to get access to it.

Summary: Our office is committed to protecting the privacy of your medical information.

- 1) We share the medical information, in your chart, with other medical care providers involved in your care so we can meet your health needs.
- 2) We share your medical information, only to the extent necessary, to collect payment for medical services and to comply with laws governing health care.
- 3) Otherwise we only disclose information to other people, companies, or institutions with your permission.

You have the right to see your medical chart.

A full version of this notice is available to you if you request it.

Signature of Patient or Patient Representative

Date

Family Dermatology

Dale L Pearlman, MD
1220 University Dr., Ste 203
Menlo Park, CA 94025

Phone: 650/325-0505
Fax: 650/325-0932
Email MD@dpearlman.biz

YOUR PREFERENCE REGARDING MEDICAL INFORMATION IN OUR OFFICE

Who may we speak with regarding your medical information?

_____ I DO NOT wish to authorize the release of any information to anybody other than myself.

OR

I, _____ hereby authorize Family Dermatology
(PRINT NAME)

to release all information regarding my care here including diagnoses, treatments and laboratory results to (i.e. family members, primary care doctors, etc):

(NAME) (RELATIONSHIP)

(NAME) (RELATIONSHIP)

(NAME) (RELATIONSHIP)

This authorization applies to all information with the exception of:

I understand that this authorization will remain valid unless otherwise rescinded by written request.

(SIGNATURE) (DATE)

I hereby rescind the above authorization.

(SIGNATURE) (DATE)