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PATIENT REGISTRATION

General information

LAST _____ FIRST_____ MIDDLE _____

DATE OF BIRTH_____SOCIAL SECURITY NUMBER _____

SEX □ M □ F DRIVERS LICENSE # _____STATE _____

MARITAL STATUS: □ Married □ Single □ Divorced □ Widowed □ Domestic Partner

PARENT/GUARDIAN NAME _____**RELATIONSHIP**_____

SOCIAL SECURITY NUMBER (Parent/Guardian) _____ **DOB (Parent/Guardian)** _____

LANGUAGE PREFERENCE _____

Do you require a translator for your visits? Yes or No (circle one)

ETHNICITY: __Hispanic __Not Hispanic __Other

RACE: __American Indian/Alaska Native __Asian __White __Black/African American __Native Hawaiian __Other Pacific Islander

Home Address

STREET ADDRESS_____ CITY _____ STATE____ ZIP

HOME PHONE _____ CELL PHONE _____

WOULD YOU LIKE TO RECEIVE TEXT UPDATES REGARDING YOUR APPOINTMENT? □ Yes □ No

EMAIL ADDRESS _____

EMPLOYER_____

OCCUPATION _____

WORK ADDRESS _____ CITY _____ STATE _____ ZIP _____

WORK PHONE _____ EMAIL ADDRESS _____

IN CASE OF EMERGENCY CONTACT _____ PHONE _____

Primary Insurance

NAME OF PRIMARY INS _____ PHONE_____

ID/POLICY NUMBER_____ GROUP NUMBER _____

SUBSCRIBER/INSURED _____ RELATIONSHIP _____ SEX _____

DATE OF BIRTH_____ SOCIAL SECURITY NUMBER_____

EMPLOYER NAME _____EMPLOYER PHONE_____

Secondary Insurance

NAME OF SECONDARY INS _____ PHONE _____

ID/POLICY NUMBER_____ GROUP NUMBER

SUBSCRIBER/INSURED _____ RELATIONSHIP_____ SEX _____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER_____

EMPLOYER NAME_____ EMPLOYER PHONE _____

I, the undersigned, assign directly to Natural Image OC, Lenore M. Sikorski, M.D. INC., all medical benefits if any, otherwise payable to me for services rendered. I understand that I will be required to present my health insurance card and drivers license to ensure coverage and identity. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I understand that I may elect to change health care providers at any time.

Signature _____ **Date** _____

Initals _____

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PATIENT QUESTIONNAIRE
(Please Print)

Name: _____ Age: _____

Profession: _____

Who is your Primary Care Provider? _____

How did you hear about our practice?

☐ Physician Referral _____

☐ Personal Referral _____

☐ Orange County Register Newspaper

☐ OC Magazine Other Magazine _____

☐ Phonebook

Internet Search:

☐ Google	☐ Bing	☐ Realself.com	☐ Facebook	☐ Yelp
☐ Yahoo	☐ Instagram	☐ Locateadoc.com	☐ Twitter	☐ Pintrest

Other Internet Search: _____

Our practice offers a full range of skin care services. Please mark the procedures that interest you:

☐ Skin Check	☐ Facelifts	☐ Hair Removal
☐ Removing Brown Spots	☐ Dermal Fillers	☐ Liposuction
☐ Skin Tightening	☐ Vein Treatment	☐ Acne Treatment
☐ Skin Tag/Mole Removal	☐ Laser Skin Resurfacing	
☐ Chemical Peels	☐ Eyelid Surgery	

Other concerns with your facial/body appearance: _____

_____

What products are you using presently and if known, what is the brand name? _____

_____

Are your current skin care products giving you the results you want? ☐ Yes ☐ No
If no, would you like us to assist you in choosing a skin care program specific to your needs?
☐ Yes ☐ No

Would you be interested in attending a seminar in our office about:

☐ Surgical Solutions to Aging or Appearance Improvement

☐ Nonsurgical Solutions to Appearance Improvement i.e., Cosmetic Lasers, Botox, and/or Dermal Fillers

☐ Skin Cancer and Skin Problems

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NOTICE OF PRIVACY PRACTICES

This notice describes how information about you as a patient of this practice, Natural Image OC/Lenore M. Sikorski, M. D., Inc., may be used and disclosed, and how to access your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

The following circumstances may require us to use or disclose your health information:

1. **To provide treatment:** We will use your health information within our office to provide you with the best health care possible. This may include administrative and clinical office procedures to schedule and coordinate care between physician, technician, nurse, and business office staff. In pathology laboratories, pharmacies or other health care personnel providing your treatment. It may be necessary to release your test results to authorize health care providers treating patients even when the provider requesting the results did not originally order the tests.
2. **To obtain payment:** We may include your health information with an invoice used to collect payment for treatment you received in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will make every attempt to work only with companies with similar commitment to the security of your health information.
3. **To conduct health care operations:** Your health information may be used during performance evaluations of our staff, during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.
4. **Communications:** Because we believe regular follow up is very important to your health, we may remind you of a scheduled appointment or that it is time for you to contact us to make an appointment. These communications may include postcards, letters, and telephone reminders. We may share your health information with those you tell us will be helping you with your home treatment, medications, or payment. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may request that we contact you at home, rather than work. We will try to accommodate reasonable requests.
5. **Required by law:** We may disclose your health information to public health authorities and health oversight agencies that are authorized by law to collect information, when required to do so by a law enforcement official, lawsuits and similar proceeding in response to a court or administrative order, when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public, for Worker's Compensation and similar programs.
6. **Consent:** You consent to allow us to download your Medication profile electronically from your Pharmacy.

Our patient medical records are kept confidential, secure, and out of reach by unauthorized persons. All reports, consultation and correspondence are reviewed by the physician prior to being filed in the medical records. A written released signed and dated by the patient/guardian must be obtained prior to the release of medical record information.

You are entitled to receive a copy of this Notice of Privacy Practices.

I _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of protected health information to carry out treatment, payment activities, health care operations and laboratory testing.

Signature: _____ Date: _____
(Parent/guardian if patient is a minor)

Initals _____

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FINANCIAL POLICY AND AGREEMENT

Our office is committed to providing excellent, affordable medical care. You have the right and responsibility of knowing the cost of your medical treatment. Should you be a cash patient, we may not ask for full payment at the time of service, although you will remain responsible for the full payment of all fees for services provided. If you have health insurance, we bill your insurance company directly, and you will be responsible for co-payments, coinsurance, deductible, and/or non-covered amounts. For your convenience, our office accepts personal checks, credit cards, and cash. Please read the following carefully, as it outlines our financial policy.

It is important that insurance patients understand how insurance billing works. Insurance companies require us to break down every component of your office visit into universal, numerical procedure codes, and charge for each code. The insurance companies will arbitrarily change, combine, and disallow procedure codes, and then apply their company's individual fee schedule. The result is the insurance company's determination of "reasonable and customary" charges - the amount they are willing to cover. The insurance company reduces the fees according to your individual policy's which applies amounts to your annual benefits (including co-payments, coinsurance, or deductible).

This method of billing, designed by the insurance industry, forces us to bill at full price procedure codes. Your insurance carrier will process the claim and determine reimbursement rates. Claims may also be denied depending on your benefits. By contracting with your insurance company, we are required to write-off the difference between the billed amount and the contracted amount ("reasonable and customary"). You will be billed for co-payments, coinsurance, or deductible. If we do not have a contract with your insurance carrier, you are responsible for the amount in full.

We are required by all insurance carriers to collect from patients co-payments, coinsurance, or deductible amounts. These fees can be reduced only in those cases where true financial hardship can be demonstrated. If you feel that you are in a position of financial hardship, please discuss your financial hardship with our patient account supervisor. In the unlikely event you stop payment, are notified of Non-Sufficient Funds or your account is turned over to Collections, you will responsible for all related costs.

I have read and understand Natural Image OC/Lenore M. Sikorski, M. D., Inc, financial policy as outlined above. The following constitutes an agreement between the undersigned patient/guarantor and Natural Image OC/Lenore M. Sikorski, M. D., Inc.

I request payment to be made directly to them of all medical benefits otherwise payable to me for services rendered. I understand any final obligations for payment are mine. Any portions of my bill not paid by insurance are my responsibility and are due and payable upon demand. I hereby authorize Natural Image OC/Lenore M. Sikorski, M. D., Inc., to release all information necessary to secure payment of benefits.

Patient Legal Name (please print clearly): _____

Signature: _____ Date: _____
(Parent/guardian if patient is a minor)

Initals _____

HEALTH HISTORY CHECKLIST

Patient Name _____ **Date** _____

Medications/Alternative medications (Vitamins, Herbs, etc.)

Please list any medications you are currently taking and the correlating diagnosis:

_____
_____
_____
_____
_____
_____

Allergies

☐ Aspirin	☐ Other allergies
☐ Barbiturates (sleeping pills)	_____
☐ Codeine	_____
☐ Iodine	_____
☐ Local anesthesia	_____
☐ Penicillin	_____
☐ Sulfa	_____
☐ Latex	_____

Do you smoke? ☐ Yes ☐ No How many per day? _____

Have you had an influenza vaccine. □ Yes □ No

Do you drink alcohol? ☐ Yes ☐ No How many drinks per day? _____

Have you had a Pneumonia Vaccine? ☐ Yes ☐ No

Do you have an Advance Directive: _____ Yes _____ No

Would you like information regarding Advance Health Directive: ___ Yes ___ No

Please note that Natural Image will not honor an Advanced Health Care Directive which indicates "Do Not Resusitate"

Please mark on Yes or No to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Do you wear contacts?	☐ Yes ☐ No	Radiation treatment	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Respiratory disease	☐ Yes ☐ No
Arthritis, rheumatism	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Rheumatic fever	☐ Yes ☐ No
Artificial heart valves	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Scarlet fever	☐ Yes ☐ No
Artificial joints	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Sinus trouble	☐ Yes ☐ No
Back problems	☐ Yes ☐ No	Heart murmur	☐ Yes ☐ No	Skin rash	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Heart problems	☐ Yes ☐ No	Special diet	☐ Yes ☐ No
		Hepatitis type_____	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
		Herpes	☐ Yes ☐ No	Swollen feet or ankles	☐ Yes ☐ No
Blood disease	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No	Swollen neck glands	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Thyroid problems	☐ Yes ☐ No
Chemical dependency	☐ Yes ☐ No	Jaw pain	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Circulatory problems	☐ Yes ☐ No	Liver disease	☐ Yes ☐ No	Tumors or growths	☐ Yes ☐ No
Congenital heart lesions	☐ Yes ☐ No	Low blood pressure	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cortisone treatments	☐ Yes ☐ No	Mitral valve prolapse	☐ Yes ☐ No	Venereal disease	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Nervous problems	☐ Yes ☐ No	Unexplained weight loss	☐ Yes ☐ No
		Pacemaker	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No	Psychiatric care	☐ Yes ☐ No		

Women

Are you pregnant? □ Yes □ No Due date: _____ Are you nursing? □ Yes □ No

Taking birth control pills? □ Yes□ No

Skin history

Do you get a lot of sun exposure, or have you had a lot of sun exposure in the past? □ Yes □ No

Have you ever had skin cancer? □ Yes □ No

Do any family members have a history of skin cancer? □ Yes □ No

Do any family members have a history of melanoma? □ Yes □ No

Have you had x-ray treatment? (acne, thyroid, etc.)? □ Yes □ No

When you are exposed to sunlight do you □ Burn □ Burn then tan □ Tan only

Initals _____

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Consent to Share Confidential Medical Information

Patient's Legal Name: _____

Birth Date: _____

I HEREBY AUTHORIZE NATURAL IMAGE OC TO SHARE:

- ☐ My medical information discussed at office visits
- ☐ My lab results
- ☐ My appointment times, dates, and reasons for the visits
- ☐ The medications I am taking
- ☐ The following information (specify):

WITH THE FOLLOWING PEOPLE:

Full Name: _____ **Relationship:** _____

Full Name: _____ **Relationship:** _____

Full Name: _____ **Relationship:** _____

I understand that I may cancel this consent at any time (in writing), but that cancelling it will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider to share my information with someone.

This authorization expires: ☐ *When I cancel it in writing* ☐ *Date:* _____

Signature: _____ Date: _____

Initals _____