



New Patient Demographics

First Name: _____ M.I.: _____ Last Name: _____ Preferred Name: _____

Sex: ☐ Male ☐ Female Gender Identity: _____ Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them

Birth Date: _____ Age: _____ Soc. Sec. #: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone #: (____) _____ ☐ Cell ☐ Home ☐ Work

Secondary Phone #: (____) _____ ☐ Cell ☐ Home ☐ Work

Can our office leave a voicemail/text message regarding appointments? ☐ Yes ☐ No

Primary Language Spoken: _____ Race: _____

Ethnicity: _____

Have you ever been a patient of our practice? ☐ Yes ☐ No Referred

By: _____

Primary Care Provider: _____ Primary Care phone #:(____) _____

Pharmacy: _____ Location: _____ Phone #:(____) _____

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Student

Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Life Partner

Emergency Contact

Emergency Contact: _____ Relation: _____ Phone #:(____) _____

Do we have permission to contact/leave medical information with your emergency contact? ☐ Yes ☐ No

If yes, select the information: ☐ Appointments ☐ Results ☐ Billing ☐ Diagnosis ☐ Complete Record

Insurance (if self-pay disregard following section)

Who is the Responsible Party for Medical Insurance? ☐ Self ☐ Other If under 18: ☐ Guardian

If Other/Guardian, Subscriber Information:

Name: _____ Relation: _____ Birth Date: _____ Phone #:(____) _____



Address: _____ City: _____ State: _____ Zip: _____

Medications

Are you on any blood thinning medication? YES NO Name: _____

Are you on any immunocompromising medications? YES NO Name: _____

Past and Current Medical Conditions

- ☐ None
- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (A-Fib)
- ☐ Cancer Type: _____
 - ☐ Skin Cancer of Unknown Type
 - ☐ Basal Cell Carcinoma (BCC) Location: _____ Date: _____
 - ☐ Melanoma Location: _____ Date: _____
 - ☐ Squamous Cell Carcinoma (SCC) Location: _____ Date: _____
- ☐ Coronary Artery Disease (CAD)
- ☐ Depression
- ☐ Diabetes
- ☐ Eczema
- ☐ Excessive Sweating with light activity or at rest - **How many days out of the week?** _____
On a scale of 1 to 10 (10 being the worst), how bad does this bother you? _____
- ☐ Hair Loss disorder
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Hypothyroidism
- ☐ Kidney disease
- ☐ Lupus
- ☐ Peripheral vascular disease (PVT)
- ☐ Stroke
- ☐ Vitiligo
- ☐ Other: _____

Allergies

- ☐ No Known Drug Allergies
- ☐ Adhesive Tape Reaction: _____
- ☐ Amoxicillin Reaction: _____
- ☐ Aspirin Reaction: _____
- ☐ Bacitracin Reaction: _____
- ☐ Codeine Reaction: _____
- ☐ Iodine Reaction: _____
- ☐ Latex Reaction: _____
- ☐ Lidocaine Reaction: _____



☐ Penicillin Reaction: _____
☐ Sulfa Medications Reaction: _____
☐ Tetracycline Reaction: _____
☐ Other: _____ Reaction: _____

Past Surgeries/Procedures

☐ None
☐ Cesarean Section (C-Section)
☐ Mastectomy
☐ Basal Cell Carcinoma Removal
☐ Botox Injection
☐ Breast Surgery
☐ Heart Surgery
☐ Joint Replacement Surgery
☐ Melanoma Removal
☐ Squamous Cell Carcinoma Removal

Have you been hospitalized in the last 12 months? YES NO Reason: _____

Family History

☐ None
☐ Autoimmune Disease Family Member: _____ Disease: _____
☐ Eczema Family Member: _____
☐ Heart Disease Family Member: _____
☐ Psoriasis Family Member: _____
☐ Skin Cancer Family Member: _____ Type of Cancer: _____

Social History

Smoking Status: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely ☐ Former Smoker ☐ Never Smoked

Alcohol Intake Frequency: ☐ Daily ☐ Occasionally ☐ Rarely ☐ Never

Recreational Drug User: ☐ Current ☐ Former ☐ Never ☐ Decline to Answer



Patient Acknowledgement & Agreement

Privacy Practices Summary

Your health information is protected under federal laws, including HIPAA and HITECH. We are committed to maintaining your privacy and will only use or disclose your medical information for:

- Treatment: Coordinating your care with healthcare providers.
- Payment: Billing insurance companies or you directly for services rendered.
- Healthcare Operations: Ensuring quality care and efficient practice operations.
- Legal Requirements: Complying with federal or state laws, public health concerns, or law enforcement requests.
- Other Disclosures: With your written authorization for purposes beyond those listed above.

You have the right to: inspect and request a copy of your medical records. Request amendments to incorrect or incomplete information. Restrict certain uses or disclosures of your information. Receive confidential communications in a manner of your choice. For the full Notice of Privacy Practices, please request a copy at the front desk. **Initials:** _____

Financial Policy Summary

- Insurance: While we will verify your insurance benefits, this is not a guarantee of payment. You are responsible for any changes to your plan and any unpaid balances.
- Payment Responsibility:
 - Co-pays, deductibles, and non-covered services are due at the time of service.
 - If insurance verification is unavailable, you will receive a bill for the balance.
 - Non-insured patients must pay in full at the time of service.
 - If your insurance requires a co-insurance payment, a minimum of \$100 is due at the time of service, with the remaining balance billed after insurance processes the claim.
- Minors: The accompanying adult is responsible for payment. A parent or legal guardian must be present for a minor's first visit.
- Delinquent Accounts: Unpaid balances may incur finance charges.
- If a collection agency is required, you agree to pay all related fees, including attorney costs.

For the full Financial Policy, please request a copy at the front desk. **Initials:** _____

I understand that skin samples taken during the visits requiring further testing will be sent to UC Davis or DPMG Dermatopathology, which will be billed separately by the respective Dermatopathology Lab. I agree that I may receive a bill and understand that this is not a Halo Skin Institute charge, but rather the Dermatopathology lab when applicable.

Initials: _____

Assignment of Benefits

I authorize payment of insurance benefits to be made directly to Halo Skin Institute for services rendered. I understand I may be responsible for charges not covered by insurance. I further authorize Halo Skin Institute to disclose necessary



medical information to my insurance company for reimbursement purposes and release them from any liability related to this disclosure. For the full Assignment of Benefits, please request a copy at the front desk. **Initials:** _____

Authorization to Release Information:

I authorize Halo Skin Institute to release and request my medical records from other healthcare providers, including my primary care physician (PCP) and any previous dermatology office or pathology service, for the purpose of obtaining payment from my insurance company or ensuring continuity of care. For the full Release of Medical Information, please request a copy at the front desk. **Initials:** _____

Information to be Released (Check all that apply):

- ☐ Full Disclosure including but not limited to: lab reports, intake notes, treatment notes, etc.
☐ Partial Disclosure: only including: _____

HIPAA Disclosure

I, _____, (the patient, or the guardian of the patient) hereby authorize Halo Skin Institute to release my medical information via postal mail. Telephone, fax, or email to the following person. **Initials:** _____

Name: _____ Relationship: _____ Phone Number: _____

- ☐ Appointments ☐ Results ☐ Diagnosis/Treatment ☐ Billing

Medical Treatment Authorization

I, the undersigned, a patient of Halo Skin Institute, request and authorize my attending physician and whomever he/she may designate as his/her associates or assistants, to administer such treatment as is medically necessary. I voluntarily consent to the use of audio services in the event of a telehealth visit to discuss diagnoses and said treatment. I voluntarily consent to said medical care, evaluation, and treatment, as well as any information release necessary to obtain such. This would include such services, care, diagnostic procedures, and/or medical treatments as the physician deems reasonable and necessary. These would include, but not be limited to, the performance of such services involving laboratory, radiology, and injections. In the event that invasive procedures are deemed medically necessary, I further understand that additional consent will be obtained and this consent might be verbal or written as circumstances dictate. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of treatment or examination. **Initials:** _____

Email Communications

I understand that I can "opt out" of receiving communications via unencrypted email by notifying Halo Skin Institute in writing. By signing below, I acknowledge the risks of communicating my health information via unencrypted email and consent to receive such communications despite those risks. I also understand that messages containing clinically relevant information may be incorporated into my medical record at the provider's discretion. **Initials:** _____

Patient Arbitration Agreement

It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.



NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE "ARTICLE 1 - PATIENT ARBITRATION AGREEMENT" OF THIS CONTRACT. YOU MUST SIGN THIS CONTRACT IN ORDER TO BE SEEN BY A PROVIDER AT HALO SKIN INSTITUTE. **Initials:** _____

By signing below, I acknowledge that I have read and understand both Consent Forms, and I have been informed of my right to request full copies at the front desk.

Patient Name (Printed): _____

Patient Signature: _____ **Date:** _____