GREEN DERMATOLOGIC MEDICAL GROUP
PATIENT REGISTRATION

(PLEASE PRINT)

Date_____

Patient Name_____ **Phone ( )**_____
LAST NAME FIRST NAME MI

Cell ( )_____

Address _____

City_____ **Zip**_____ **State**_____

Date of Birth_____ **Gender:** MALE FEMALE

Marital Status: S M D W **Race** _____

Social Security # _____ **Drivers License #** _____

Email Address _____

Employer _____ **Occupation**_____

Employer Address _____ **Work #** _____

Name of your Spouse (or nearest relative) _____ **Relationship**_____

Were you referred to our office by another physician? YES NO
If yes, what is physician's name? _____

May we contact you at home with results? YES NO

Do you prefer we leave at your: (Circle all that apply) HOME WORK VOICEMAIL CELL PHONE

PLEASE PRESENT INSURANCE CARDS TO THE RECEPTIONIST SO COPIES CAN BE MADE

I certify that the above information is true, and I consent to any medical or surgical treatment rendered the patient under the general and special instructions of the physician.

I hereby assign all benefits to Green Dermatologic Medical Group for services rendered to me. I authorize any holder of medical information about me to release to my insurance company any information needed to determine benefits or the benefits payable for related services. I understand my signature requests that payment be made to Green Dermatologic Medical Group, and authorize release of medical information necessary to pay the claim. I have given all my insurance information for billing purposes and understand the billing procedures.

I understand that I am responsible for all charges not covered by my insurance policy including but not limited to co-payments, deductibles, and non-covered services. I also agree to complete all necessary paperwork in order for my claim to be paid by my insurance company and accept full liability if payment is not made in my behalf by my insurance company.

You signature below indicates that you understand and accept the policies listed above.

_____ _____

Patient Signature Date

GREEN DERMATOLOGIC MEDICAL GROUP

History and Intake Form

Date _____

Name _____ **Email** _____

Reason for today's visit _____

Medical History: (please circle all that apply)

Anxiety Disorder
Arthritis
Asthma
Atrial Fibrillation
Benign prostatic hyperplasia
Cerebrovascular accident
Chronic obstructive lung disease (COPD)
Coronary Arteriosclerosis
Depressive Disorder
Diabetes
Disease caused by Covid-19
Elevated blood pressure
End Stage Renal Disease
Epilepsy
Other _____

NONE
Gastroesophageal reflux disease (GERD)
History of hypertension
Hearing loss
HIV/AIDS
Hypercholesterolemia (high cholesterol)
Hyperthyroidism
Hypothyroidism
Inflammatory disease of liver
Leukemia
Malignant Lymphoma
Malignant tumor of breast (Breast Cancer)
Malignant tumor of colon (Colon Cancer)
Malignant tumor of prostate (Prostate Cancer)
Radiation therapy treatment management
Transplantation of bone marrow

Past Surgical History: (please circle all that apply)

Abdominoperineal resection
Bilateral replacement of knee joints
Biopsy of breast
Biopsy of prostate
Coronary artery bypass graft
Entire transplanted kidney
Excision of basal cell carcinoma
Excision of melanoma
Excision of squamous cell carcinoma
History of Colostomy (due to bowel surgery)
History of tubal ligation
History of appendectomy
History of bilateral mastectomy
History of cholecystectomy (gallbladder removal)
History of colectomy (removal of part of colon)
History of liver excision
History of coronary angioplasty (blocked artery)
History of tissue graft heart valve replacement
History of total cystectomy (removal of bladder)
History of transurethral prostatectomy (treatment for enlarged prostate)
Hysterectomy

NONE
Low anterior resection of rectum
Lumpectomy of breast
Lumpectomy of right breast
Lumpectomy of left breast
Mastectomy of left breast
Mastectomy of right breast
Mechanical heart valve replacement
Oophorectomy (removal of ovaries)
Pancreatectomy (removal of pancreas)
Percutaneous extraction of kidney stone
Splenectomy (removal of spleen)
Surgical biopsy of skin
Total nephrectomy (removal of kidney(s))
Total orchidectomy (removal of testicles)
Total replacement of left hip joint
Total replacement of left knee joint
Total replacement of right hip joint
Total replacement of right knee joint
Transplantation of heart
Transplantation of liver

Other _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asteatosis cutis (dry skin)
Basal Cell Skin Cancer
Contact dermatitis due to Poison Ivy
Dysplastic Nevus of skin (atypical moles)
Eczema
History of asthma
Other _____

NONE
History of Hay Fever
Malignant Melanoma
Pruritus of scalp (itchy scalp)
Psoriasis
Squamous Cell Carcinoma
Sunburn of second degree

Do you wear sunscreen? Yes No If yes, what SPF?_____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____

Do you have any direct (by blood) family members that have any skin problems? (ie. skin cancer, eczema, etc):
If yes, which relative(s)? _____

Pharmacy _____ **Street/City** _____

Medications: *(Please enter **all current medications with dosages** and frequency or state NONE if no meds)*

_____
_____
_____

Have you received the following vaccination/immunization:

Flu Shot? YES NO If yes, please give approximate date:_____
Pneumonia? YES NO If yes, please give approximate date:_____
Do you have an "Advance Care Plan?" YES NO

Allergies: (*Please enter **all allergies and reactions** or state NONE if no allergies)*

_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:
Never Smoked
Quit: Former Smoker
Smokes less than daily
Smokes Daily

Alcohol Use:
None
Less than 1 drink a day
1 – 2 drinks a day
3 or more drinks a day

Green Dermatologic Medical Group
A Medical Corporation
Roger E. Green, M.D. Rollin M. Green, M.D.
657 Camino De Los Mares, Suite 242, San Clemente, CA 92673
(949) 496-6066 Fax (949) 496-6497

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Green Dermatologic Medical Group to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Green Dermatologic Medical Group's Notice of Privacy Practices provides a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Green Dermatologic Medical Group reserves the right to revise its Notice of Privacy Practices at Green Dermatologic Medical Group anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Green Dermatologic Medical Group's Privacy Officer at 657 Camino De Los Mares, Suite 242, San Clemente, CA 92673.

With this consent, Green Dermatologic Medical Group may call my home and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. Green Dermatologic Medical Group may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, I also acknowledge that Green Dermatologic Medical Group is not liable if my access codes to our electronic medical records system are personally lost by you, shared by you or stolen from you.

This consent authorizes Green Dermatologic Medical Group to provide medical information to the following individuals. This authorization shall remain in effect until withdrawn with a request in writing.

Name	Relationship
_____	_____
_____	_____

I have the right to request that Green Dermatologic Medical Group restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement signing this form; I am consenting to Green Dermatologic Medical Group's use and disclosure of my PHI to carry out TPO.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Green Dermatologic Medical Group may decline to provide treatment to me.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Patient's Name

Notice of Privacy Practices Acknowledgment Form

I am a patient (or legal guardian of a patient) of Green Dermatologic Medical Group. I hereby acknowledge I have been advised of Green Dermatologic Medical Group's Notice of Privacy Practices.

_____ _____
Signature of Patient (or legal guardian) Date

_____
Patient's Name

Updated 5/23/22

GREEN DERMATOLOGIC MEDICAL GROUP
A Medical Corporation
Roger E. Green, MD Rollin M. Green, MD
Diplomates American Board of Dermatology
657 Camino De Los Mares, Suite 242, San Clemente, California 92673
Phone: 949-496-6066 Fax: 949-496-6497

48 Hour Appointment Cancellation Policy

Green Dermatology has a 48 hours cancellation/rescheduling policy.
If you miss your appointment, cancel or change your appointment with less than 48 hours' notice, you will be charged $50.00 ($75.00 for surgeries).

This policy is in place out of respect for our staff and patients. Cancellations with less than 48 hours' notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Dr. Roger E. Green as described above.

Thank you for your understanding and cooperation.

Sign:_____ Date:_____