Yorba Linda Dermatology

16960 Bastanchury Road Suite i Yorba Linda CA 92886

PATIENT REGISTRATION

Last Name: _____ **First Name:** _____ **M.I.**_____ **Sex:** ☐M ☐F

DOB: _____ **Age:** _____ **Social Security #:**_____

ADDRESS:

Address: _____

City: _____ **State:** _____ **Zip:** _____

PHONE:

Home: _____ **Preferred number:** ☐Home ☐Cell ☐Work

Mobile: _____ **May we leave a detailed message?** ☐Yes ☐ No

Work: _____ **May we text appointment reminders?** ☐Yes ☐ No

EMAIL:

Email address: _____

May we email appointment reminders? ☐Yes ☐ No

Would you like to be notified of promotions and events? ☐Yes ☐ No

CONSENT TO DISCUSS CARE:

If you are 18 years or older we cannot discuss your care with other family members, spouses or caretakers without your consent. Do you authorize consent for any other individuals? ☐Yes ☐ No

If yes: _____ _____
name **phone number**

DEMOGRAPHICS:

Ethnic Group:	**Race:**	
☐Hispanic or Latino	☐White	☐Black or African American
☐Not Hispanic or Latino	☐American Indian / Alaska Native	☐Native Hawaiian / Pacific Islander
☐Unknown	☐Asian	☐Other

PRIMARY CARE PHYSICIAN:

Name: _____ **City:** _____

REFERRAL:

How did you hear about us? _____

PHARMACY:

Preferred pharmacy: _____ **City:** _____

INSURANCE INFORMATION

ELIGIBILTY: Please be aware that your health insurance policy is a contract between you and your insurance company. It is an agreement that your insurance will pay for covered medical services as long as your premiums are paid. Because they may not pay for every service, you will be responsible for any non-covered charges. We will verify your eligibility before your visit but please keep in mind that a determination of benefits with your carrier is NOT a guarantee of payment.

DEDUCTIBLES: Before your visit, we will verify your deductible and/or co-pay amounts. If your annual deductible for the calendar year has not been met, you will be responsible for any charges incurred during your visit, payable at the time of service. We will also collect any co-pay amounts at the time of service.

OUTSIDE SERVICES: Please be aware that your care may require the use of laboratory or pathology evaluation. These studies are not performed at our practice so please understand that you will receive a separate bill from the pathologist or laboratory providing those services. If you have a preference for a specific facility, please notify us prior to any procedure so that we can do our best to accommodate you.

I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for the services provided. I also authorize Malcolm Ke, M.D./ Yorba Linda Dermatology or my insurance company to release any information required to process my claim.

Signature: _____ **Date:** _____
Patient or Legal guardian

Printed name of Legal guardian: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of Dr. Ke's Notice of Privacy Practices

Signature: _____ **Date** _____
Patient or legal guardian

CONSENT FOR TREATMENT:

I understand that many dermatological conditions are chronic and require ongoing care. All medications have side effects and there are risks to any medication prescribed. Dermatologists frequently diagnose skin growths by performing a skin biopsy and treat skin growths by freezing, cauterization, and/or cortisone injection.

I understand that there are risks to any procedure and that these risks include, but are not limited to:

- Temporary or permanent discoloration
- Scarring
- Pain
- Infection
- Bleeding
- Nerve damage

I consent to having these procedures done as part of my care and treatment. I also have the right to refuse any treatment at any time. This authorization and consent shall remain in effect for this visit and all future visits to the office.

By signing below, I authorize evaluation and treatment by Malcolm Ke, M.D./Yorba Linda Dermatology

Signature: _____ **Date** _____
Patient or legal guardian

NAME:_____
DOB:_____

Patient Health Questionnaire

All information in this questionnaire is strictly confidential and will become part of your medical record.

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
- ☐Hypertension
- ☐HIV/AIDS
- ☐Hypercholesterolemia
- ☐Hyperthyroidism
- ☐Hypothyroidism
- ☐Leukemia
- ☐Lung Cancer
- ☐Lymphoma
- ☐Prostate Cancer
- ☐Radiation Treatment
- ☐Seizures
- ☐Stroke
- ☐Other_____

Past Surgical History (including dates):

_____

_____

_____

Skin Disease History:

- ☐Acne
- ☐Actinic Keratoses
- ☐Asthma
- ☐Blistering Sunburns
- ☐Dry Skin
- ☐Eczema
- ☐Flaking or Itchy Scalp
- ☐Hay Fever/Allergies
- ☐Poison Ivy
- ☐Precancerous Moles
- ☐Psoriasis
- ☐Other: _____

History of Skin Cancer:

	Location	Year
☐Basal Cell:		
☐Squamous cell:		
☐Melanoma:		
☐Other:		

☐Unknown

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, who? _____

NAME:_____
DOB:_____

Medications: (Prescription, over-the-counter, and herbal)

Name	Dose

Allergies:

_____

_____

Social History:

Cigarette Smoking:
- ❒Never smoked
- ❒Quit: former smoker
- ❒Current every day smoker
- ❒Current some day smoker

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

Employment:

Employer: _____ Occupation: _____

Review of Systems:

Do you have any of the following?
- ❒Chest pain
- ❒Shortness of breath
- ❒Fever or chills
- ❒Unintentional weight loss
- ❒Night sweats
- ❒Joint aches
- ❒Headache

Alerts:

Do you have any of the following?
- ❒Pacemaker
- ❒Defibrillator
- ❒Artificial joints within past two years
- ❒Artificial heart valves
- ❒Premedication prior to procedures
- ❒Blood thinners
- ❒Pregnancy or planning a pregnancy
- ❒Breastfeeding
- ❒Bleeding disorder
- ❒Allergy to adhesive
- ❒Allergy to latex
- ❒Allergy to topical ointments
- ❒Allergy to lidocaine
- ❒Rapid heart beat with epinephrine
- ❒Problems with scarring/keloids

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** 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 rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services _____
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

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 OF THIS CONTRACT.

By: _____ _____
Patient's or Patient Representative's Signature Date

By: _____ _____
Physician's or Authorized Representative's Signature Date

Malcolm Ko M.D. APC
Print or Stamp Name of Physician, Medical Group, or Association Name

By: _____
Print Patient's Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.