

Noel T. Chiu, M.D., AMC
James A. Jewell, P.A.-C
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www.diablodermatology.com

In order to serve you properly, we will need the following information. **PLEASE PRINT.** All information will be strictly confidential.

Patient Information Today's Date ____/____/____

Name _____
LAST FIRST M.I.

Mailing Address _____
NUMBER STREET CITY STATE ZIP CODE

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Date of Birth ____/____/____ Age _____ Sex _____ Marital Status _____

If Student: Full Time Part Time Name of School: _____

Nearest friend or relative not residing with you? _____

Relationship: _____ Phone (____) _____

PARENT OR RESPONSIBLE PARTY (If different from patient)

Name _____
LAST FIRST M.I.

Mailing Address _____
NUMBER STREET CITY STATE ZIP CODE

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Date of Birth ____/____/____ Sex _____ Relationship to Patient: _____

MAY WE LEAVE PERSONAL MEDICAL INFORMATION ON YOUR ANSWERING MACHINE OR CELL PHONE? Yes No

INSURANCE INFORMATION (Please present insurance card at time of check in)

Primary Insurance Name _____ Secondary Insurance Name _____

Name of Subscriber _____ Name of Subscriber _____

Date of Birth ____/____/____ Date of Birth ____/____/____

Insured's I.D. # _____ Insured's I.D. # _____

Group # _____ Group # _____

Employer Name _____ Employer Name _____

Employer Address _____ Employer Address _____

Employer Phone (____) _____ Employer Phone (____) _____

Relationship of Patient to Insured _____ Relationship of Patient to Insured _____

In case of Emergency, who should be notified? _____ Phone (____) _____

Relationship to Patient: _____ Primary Care Physician of Patient: _____

ALL ACCOUNTS ARE DUE AND PAYABLE AT THE TIME OF THE VISIT UNLESS SPECIAL ARRANGEMENTS ARE MADE IN ADVANCE. IT IS ILLEGAL FOR PHYSICIANS TO WAIVE INSURANCE DEDUCTIBLES AND CO-PAYMENTS.

I authorize this office to release any information necessary to expedite insurance claims. I assign to Dr. Noel Chiu direct payment of insurance benefits to which I am entitled for medical and/or surgical care. I understand that I am responsible for all charges, regardless of insurance coverage. I will inform Dr. Noel Chiu's office of any change in insurance coverage. Any payment denied due to my failure to inform Dr. Noel Chiu's office of insurance changes or related errors in referral authorizations, will be my financial responsibility.

I authorize Dr. Noel Chiu and/or James A. Jewell, P.A. to give me appropriate medical care by today's standards. I acknowledge I shall be financially responsible for all elective-cosmetic procedures not covered by my insurance plan.

I hereby authorize Dr. Noel Chiu and/or James A. Jewell, P.A. to treat my son/daughter as necessary.

Patient, Parent, or Guardian Signature _____ Date ____/____/____

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MEDICAL HISTORY

Patient Name: _____ Date: _____

Referred by: Self Family/Friend Dr. Name: _____

1. Are you aware of being allergic to or have you ever reacted adversely to any medications or substance? No Yes

List: _____

2. Are you currently taking/using any medication, drugs, pills, and/or vitamins? No Yes List or provide separate sheet: _____

3. Please indicate the reason for your appointment: _____

a. How long has the problem been present? _____

b. Where is it located? _____

c. Have you received treatment for this problem elsewhere before? No Yes When? _____
Where? _____

d. What are your symptoms? (Describe severity and quality) _____

4. Indicate which of the following you have had or have at present:

Skin:

- abnormal scarring
- poor healing
- excessive bleeding after procedures
- other skin disorders _____

Cardiovascular:

- normal
- angina
- artificial heart valve
- pacemaker
- hypertension
- heart attack (when?) _____

Neurological:

- normal
- stroke
- seizures
- other: _____

Women:

- pregnant (currently)
- if preg., due date _____
- nursing (currently)
- taking birth control (curr.)
- date of last period: _____

Hematologic/Lymphatic:

- normal
- anemia
- bleeding problems
- enlarged lymph nodes

Respiratory:

- normal
- asthma
- emphysema
- other lung problems: _____

Psychiatric:

- normal
- depression
- anxiety attacks
- other: _____

Constitutional Symptoms:

- none
- weight loss
- fever
- other: _____

Gastrointestinal:

- normal
- stomach ulcer
- colitis
- liver damage
- other GI problems: _____

Endocrine:

- normal
- diabetes
- thyroid
- kidney disease

Eyes/Ears/Nose/Throat:

- normal
- glaucoma
- hearing aid
- plastic surgery

Musculoskeletal:

- normal
- arthritis
- artificial joints
- other: _____

Infections:

- none
- hepatitis
- HIV/AIDS
- tuberculosis(T.B.)
- other: _____

5. Do you have or have you had any disease, condition, or problem not listed above? No Yes

List: _____

6. **Past History:** Have you ever been diagnosed with a skin cancer or any other type of cancer or tumor? No Yes

List: _____

7. **Family History:** Skin cancer: None Melanoma Basal Cell Squamous Cell

8. **Social History:** Previous Sunlight Exposure: mild moderate extensive tanning bed use

Do you smoke? no former yes Occupation: _____

COMPLETED BY: _____ DATE: _____
(Patient's/Guardian's Signature)

REVIEWED BY: _____ DATE: _____
(Medical Provider's Signature)

DIABLO DERMATOLOGY FINANCIAL POLICY

We appreciate your confidence in choosing Diablo Dermatology. Please review our financial policy below:

Copayments/Co-insurance: If you are responsible for a copayment/co-insurance through your insurance carrier you are required to pay each time you are seen. The copayment must be paid at the check-in desk prior to your visit. If you are not prepared to pay, the visit will be rescheduled.

Deductibles: In addition to the copayment/co-insurance, some insurance plans have a deductible. You are required to pay this at the time of the visit. If after billing your insurance they inform us that you are responsible for an additional amount, we will bill you. Please pay your bill promptly after the first statement. If you do not understand the reason you owe a balance, please contact your insurance for further explanation.

The Adult/Guardian who brings the minor in will be responsible for all copayments, co-insurances, and/or deductibles at the time of the visit. We do not forward bills to other parties regardless of court rulings or divorce decrees.

We accept Visa and Mastercard for your convenience.

Referrals: If you are enrolled in a plan which requires a referral from your Primary Care Physician, you must have the referral with you in order to be seen by the provider. If you arrive without your referral or we have not received it from your Primary Care Physician's office, you have two options:

1. You can reschedule; or

2. You can pay for the visit at the time of service, cash or credit accepted. If the correct referral is received within a three-day period, your payment will be refunded to you.

Our staff is dedicated to working with your insurance carrier to get the best possible reimbursement. Patients, however, also have the responsibility regarding their coverage. We appreciate your assistance in working with our staff.

I have read the above and understand my obligations.

Patient, Parent or Guardian Signature: _____ Date: _____