DIABLO DERMATOLOGY
3436 Hillcrest Ave., Suite 150, Antioch, CA 94531 · (925) 754-6767
www.diablodermatology.com

MEDICAL HISTORY

Patient Name: _____ **Date**: _____

Referred by: ☐ Self ☐ Family/Friend ☐ Doctor **Doctor's Name**: _____

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

*List of medication allergies or other medical allergies: _____

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

3. Please indicate the reason for your appointment: _____ Other symptoms: _____

a. How long has that problem been present? _____ b. Is it: ☐ worsening ☐ staying the same ☐ improving

c. Where is it located? _____ d. Is it ☐ constant ☐ comes and goes

e. How severe is it?(check or circle one) mild 1 2 3 4 5 6 7 8 9 10 severe

Pain? ☐ none mild 1 2 3 4 5 6 7 8 9 10 severe Itch? ☐ none mild 1 2 3 4 5 6 7 8 9 10 severe

f. Quality: What other symptoms are you experiencing (aching, burning sensation, etc.) _____

g. Does anything make your problem worse or better? _____

h. Have you been treated previously for this before? ☐ No ☐ Yes If yes, when & where? _____

Previous Treatments? _____

4. Indicate which of the following you have had or have at present (Review of Systems):

Gastrointestinal (ex:Ulcer, Liver Damage):
☐ Normal
☐ Abnormal, explain: _____

Cardiovascular (ex. Heart attack, Hypertension):
☐ Normal
☐ Abnormal, explain: _____

Hematologic/Lymph (ex. Anemia,bleeding):
☐ Normal
☐ Abnormal, explain: _____

Respiratory (ex. Asthma, Emphysema):
☐ Normal
☐ Abnormal, explain: _____

Constitutional (ex. Weight loss, Fever):
☐ Normal
☐ Abnormal, explain: _____

Psychiatric (ex. Depression, Anxiety):
☐ Normal
☐ Abnormal, explain: _____

Eyes/Ears/Nose/Throat (ex. Glaucoma):
☐ Normal
☐ Abnormal, explain: _____

Musculoskeletal (Arthritis, Artificial joints):
☐ Normal
☐ Abnormal, explain: _____

Women
☐ Pregnant, if yes, due date: _____
☐ Nursing currently
☐ Taking birth control currently
☐ Date of last period: _____

Neurological (ex. Stroke, Seizures, Tremors):
☐ Normal
☐ Abnormal, explain: _____

Endocrine (ex. Diabetes, Thyroid disease):
☐ Normal
☐ Abnormal, explain: _____

Infections (ex. Hepatitis, HIV/AIDS, T.B.):
☐ None ☐ Hepatitis
☐ HIV/AIDS ☐ 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: _____ Smoker: ☐ No ☐ Yes ☐ Former

7. Social History: Previous Sunlight Exposure: ☐ Mild ☐ Moderate ☐ Extensive ☐ Tanning bed use

8. Family History: Skin cancer: ☐ None ☐ Melanoma ☐ Basal Cell ☐ Squamous Cell Acne ☐ Psoriasis ☐

COMPLETED BY: X _____ **DATE:** _____

(Patient's/Guardian's Signature)

REVIEWED BY: X _____ DATE: _____

Noel T. Chiu, M.D.

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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) (MI)

Mailing Address_____
(NUMBER) (STREET) (CITY) (STATE) (ZIP CODE)

Email Address: _____ Occupation: _____

Home #: (_____) _____ Cell #: (_____) _____ Work #: (____) _____

How do you prefer to be contacted? Home Phone____ Cell Phone____ Email_____
(Please check one)

Date of Birth _____/_____/_____ Age _____ Sex _____ Martial Status _____

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

EMERGENCY CONTACT: _____

Relationship: _____ Phone (_____) _____

PARENT OR RESPONSIBLE PARTY (If different from patient)

Name_____
(LAST) (FIRST) (MI)

Mailing Address_____
(NUMBER) (STREET) (CITY) (STATE) (ZIP CODE)

Home #: (_____) _____ Work #: (____) _____ Cell #: (____) _____

Date of Birth _____/_____/_____ Sex _____ Relationship to the Patient _____

DO WE HAVE PERMSSION TO: (Please circle your answer)

Leave a message on your home answering machine? (example, to confirm appointment, lab results)	YES	NO	NA
Leave a message at your place of employment?	YES	NO	NA
Leave a message on your cell phone?	YES	NO	NA
Send an appointment reminder card to your home?	YES	NO	NA
Send an Email or text message to confirm appointments?	YES	NO	NA
Discuss your medical condition with any member of your home?	YES	NO	NA

If yes, person's names and relationship to you:

_____

ALL ACCOUNTS ARE DUE AND PAYABLE AT THE TIME OF THE VISIT UNLESS SPECIAL ARRANGEMENTS ARE MADE IN ADVANCE. WE ARE REQUIRED TO ABIDE BY THE CONTRACTURAL AGREEMENT MADE WITH THE INSURANCE COMPANIES.

I authorize this office to release any information necessary to expedite insurance claims. I assign to Dr. Noel Chiu direct payments 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 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 Associates 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 Associates to treat my son/daughter as necessary.

Patient, Parent, or Guardian Signature X_____ **Date** _____/_____/_____

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DIABLO DERMATOLOGY'S COMMITMENT TO QUALITY MEDICAL CARE

Diablo Dermatology is committed to providing you with high quality medical care. We participate in continuing medical education to keep our knowledge and skills current and strive to ensure that our patients receive high quality medical care from this practice.

We also understand that as a patient, you may at times have concerns or complaints about our services. We encourage you to communicate your concerns to us or our staff. **Please tell us if you have a complaint – we value your feedback.** Please tell us if you have questions about your care, suggestions to improve the delivery of health care in this office, or complaints about any aspect of your treatment. We appreciate being a part of your health care team and **greatly** value your feedback.

If we are not able to answer your concern or complaint to your satisfaction, please contact the Alameda-Contra Costa Medical Association. If you have a complaint and we cannot resolve it together, we can refer to you an impartial dispute resolution committee of our local medical association. As a member of the medical association, we have made a commitment to have any complaints you bring against us reviewed by a committee of peers. **Contact ACCMA at 510-654-5383.**
If the above suggestions are not satisfactory, or for any reason, you may contact the Medical Board of California. We offer this *NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California (800-633-2322 or www.mbc.ca.gov).

I have read and understand the options available to me in regards to my medical care. I understand that medical doctors are licensed and regulated by the Medical Board of California.

X_____ **X**_____ **X**_____
Patient/Patient Representative Name – Please Print **Patient/Patient Representative Signature** **Date**

***In compliance with Business and Professionals Code Section 138, Title 16, California Code of regulation Section 1355.4, effective June 27, 2010.** The Medical Board of California requires that we provide this notice to consumers.

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1 BUSINESS DAY APPOINTMENT CANCELLATION POLICY

Diablo Dermatology has a 1 Business day cancellation / rescheduling policy.

After two No Show or Last minute Cancellations, the practice has the right to discharge the patient and ask that you look for another Dermatologist.

If you miss your appointment, cancel, or change your appointment with less than 1 business day advance notice, you will be charged $25.

This policy is in place in consideration of others. Cancellations with less than 1 business day 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.
For example, if you have an appointment scheduled for Monday at 11am, you must cancel before the appointment by the previous Friday 11am to avoid a cancellation charge.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Diablo Dermatology as described above.

X_____ **X**_____ **X**_____
Printed Name **Signature** **Date**

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NOTICE OF PRIVACY PRACTICES

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. With your consent we may use and disclose your Protected Health Information(PHI) in order to carry out Treatment, Payment, and Health Care Operations(TPO).

As our patient, you have the right to restrict how we use or disclose your PHI to carry out the TPO.

As a patient of Noel T. Chiu M.D., AMC, you have the right to receive and review a detailed copy of our Privacy Practices prior to signing this form, in addition a copy can be provided to you upon request.

I have read and reviewed this policy which was updated as of 12/11/13.

X_____ **X**_____ **X** _____
Signature of Patient of Legal Guardian **Patient's Name** **Date**

Please list below if you would like to add anyone whom we can release your medical information to.

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

DOB: _____ DOB: _____

I understand that it is my responsibility to notify Diablo Dermatology should any of the above information change.

X_____ **X**_____
Signature of Patient, Parent, or Guardian **Date**

Complaints about this Notice of Privacy Practices or how this medical practice handles your PHI should be directed to our privacy officer. You will not be retaliated upon for filing a complaint. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to: Region IX, Office for Civil Rights, U.S. Department of Health and Human Services
907 7th Street, Suite 4-100, San Francisco, Ca 94103
(415) 437-8310; (415) 437-8311 TDD; or (415) 437-8329 Fax
www.hhs.gov/ocr/privacy/hipaa/complaints/hipaacomplaint.pdf

In addition, you can download a full version of our Notice of Privacy Practices on our website: www.diablodermatology.com

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DIABLO DERMATOLOGY FINANCIAL POLICY

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

Copayments/Coinsurance: If you are responsible for a copayment/coinsurance through your insurance carrier, you are required to pay each time that 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/coinsurance, 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 that 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, coinsurances, and/or deductibles at the time of the visit. We do not forward bills to other parties regardless of court rulings or divorce decrees.

For your convenience we accept Cash, Credit or Debit cards.

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 our 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 your appointment; 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 you and your insurance carrier in resolving any issues applicable to our services to get the best possible reimbursement. However, patients also have the responsibility regarding their own coverage, allowed amounts, and follow up if any refund is owed.

We appreciate your assistance in working with our staff.

I have read the above and understand my financial obligations.

Patient, Parent or Guardian Signature: X _____ Date: X _____