9850 Genesee Avenue, Suite 500
La Jolla, CA 92037
858-657-0267 (p)
858-657-9485(f)

Darrell W. Gonzales, MD

Dear Patient,

Thank you for choosing Coastal Medical and Cosmetic Dermatology for your dermatological needs. We are located in the XIMED building on the campus of Scripps Memorial Hospital in La Jolla. Our practice welcomes new patients, and we are delighted you have chosen us.

Our goal is to make your experience in our office as pleasant as possible. To help minimize your waiting time, we have included the patient forms necessary for your first visit. Please complete the forms and bring them *along with your insurance card* to your appointment.

Our billing department is happy to bill your insurance for you. If you are uncertain as to whether or not we are contracted with your insurance, *you* should contact your insurance company *prior* to your visit. If you have any questions or need to reschedule your appointment, please do not hesitate to contact our office at (858) 657-0267.

We look forward to seeing you.

Dr. Darrell Gonzales, M.D.

Coastal Medical and Cosmetic Dermatology

PATIENT INFORMATION (Please PRINT Clearly with BLACK Ink)

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Date of Appointment: ____________________

Patient's Legal Name: ____________________________________ Preferred Name: ______________________

Email Address: ____

Address: ____

City: ___________________________ State: _____________ Zip: _______________________________________

Home#:(_____)_____________ Work#:(_____)_____________ Mobile#:(____)____________________

Date of Birth: ____/____/____ Age: _______ Sex: _______ SS#: __________-______-__________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Name of Spouse: ______________________________ # of Children: _________________________________

Patient's Occupation: ___________________________ Patient's Employer: ____________________________

Emergency Contact: ____________________ Relationship: __________________ Phone#:(_____)________________

Pharmacy Name/Location: ________________________________ Pharmacy Phone #: (______)________________

How did you find us?

☐ Physician (Name :_______________________) ☐ Family or Friend (Name_____________________________)

☐ Yellow Pages ☐ Insurance Book ☐Internet ☐Newspaper Ad ☐Other:________________________

INSURANCE #1 POLICY HOLDER ☐ self ☐ spouse ☐ parent ☐ other

Insurance Policy Holder's Name (*if not patient*): ____

Relationship to Patient:____________________ **Date of Birth:** ____/____/____ **SS#:**________-_____-_______

Employer: ____

Address: (if different from above) ____

City: __________________________ State: ___________ Zip: _________ Contact Ph# _____________________

If you have a secondary policy, please fill out the information below:

INSURANCE #2 POLICY HOLDER ☐ self ☐ spouse ☐ parent ☐ other

Insurance Policy Holder's Name (*if not patient*): ____

Relationship to Patient:____________________ **Date of Birth:** ____/____/____ **SS#:**________-_____-________

Employer: ____

Address: (if different from above) ____

City: ________________________ State: ____________ Zip: __________ Contact Ph# ____________________

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Please read and sign below: I understand that regardless of my insurance coverage, I am financially responsible for all medical services received.
I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments, co-shares and deductibles will be collected.

It is the patient's responsibility to notify this office if your insurance plan(s) requires prior authorization before services are rendered. IF PRIOR AUTHORIZATION IS REQUIRED AND NOT OBTAINED, YOU ARE FULLY RESPONSIBLE FOR ALL CHARGES INCURRED.

Patient / Responsible Party Signature ______________________________ **Date:** __________

Date of Appointment: ____________________ Provider: ________________________

Name: ____

Date of Birth: _____/_____/_____ Age: ________ Gender: ________

Allergies: ____

Current Medications: ____
____

Reason for today's visit: ____
____

Past Medical/Family History: Check if you personally have or anyone in your family has:

	Self	Relative		Self	Relative		Self	Relative
Allergies			Asthma			Arthritis		
Eczema			Lung Disease			Diabetes		
Hay Fever			Skin Cancer			Heart Disease		
Hives			Malignant Melanoma			Hypertension		
Psoriasis			Other Cancer			Tuberculosis		

Current or Past Problems With:

	Yes	No	If yes, explain
General Health			
Eyes			
Ears/Nose/Throat/Mouth			
Heart			
Lungs			
Stomach/Bowel			
Kidneys			
Arthritis/Muscles/Joints			
Skin			
Headaches/Seizures			
Psychiatric			
Thyroid/Diabetes			
Blood/Bleeding Disorder			
Allergic/Immunologic			

Major Medical Illnesses/Surgeries: ____________________________________

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Female: Are you pregnant? ☐ Yes ☐ No Planning to become pregnant? ☐ Yes ☐ No

Social History:
Do you use alcohol? (include frequency)____________________ Do you smoke?(include frequency)____________________

Hobby/Leisure Activities: ____

____

Reviewed (Provider Signature): ____________________________________ ***Date:*** ______________

PHARMACY INFORMATION:

Is there a pharmacy that you use regularly? If so please list the name of the pharmacy and the street where it is located. We have most San Diego County pharmacies on file.

Pharmacy Name:____

Address or Street Name:____________________________________

Phone Number:____

STUDENTS:

If you are a student, covered under your parent or guardian's insurance plan, Please list your parents information below.

Name(s)____

Address:____

____

Phone Number:____

If you are over 18 years old, do we have permission to speak to your parents about your care?
Yes_____(Please initial)
No_____ (Please initial)

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Acknowledgement of Receipt of Notice of Privacy Practices

Privacy Officer can be reached at (858) 657-0267

I hereby acknowledge that I received a copy of Coastal Medical and Cosmetic's notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available in the reception area, and that I will be offered a revised copy at my next appointment if the Notice of Privacy Practices has been amended.

Date: ______________________

(PRINT) **Name of Patient:** ____

Responsible Party:

☐ **Self /** Patient Signature: ____________________________________

☐ **Other /** Responsible Party Signature: ____________________________________

Responsible Party *(PRINT)* your name: _____________________________

Telephone: _________________________

Please indicate your relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of incompetent patient

☐ Beneficiary or personal representative of deceased patient

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Health Insurance Portability and Accountability Act (HIPAA)

The primary purpose of HIPAA is to enhance health insurance accessibility for people changing employers or leaving the workforce. Provisions were also designed to encourage transmission of confidential health care data electronically, streamlining claims transactions. In return for legislating significant savings for health plans and providers, Congress imposed a series of privacy and security requirements to assure that electronically transmitted data would remain confidential and secure. In addition, Congress and privacy advocates (including physicians) were concerned that the growing use of electronic means to transmit healthcare data increased the risk to the public that the data would be compromised. Many members of the public have acknowledged that they have withheld information from a physician out of concern for security of their records and many physicians report that they have similarly failed to record certain information in the medical record due to the same fear. Standardization of privacy regulations was enacted.

Privacy standards include many mandates, including the following:

- Uniform electronic transaction standards for healthcare data.
- Privacy and confidentiality provisions. Medical practices must obtain specific authorization from patients before they may use or disclose information in many circumstances.
- Security procedures to protect electronically maintained health information
- Medial practices will generally need to provide patients with written notice of their office's privacy practices and the patients' privacy rights.
- In general, patients will be able to access their personal medical records, and to request changes to correct any errors. Patients may generally request an accounting of non-routine uses and disclosures of their health information.

Coastal Medical and Cosmetic Dermatology has always been committed to ensuring confidentiality and privacy of records and related information for all patients. When sharing private information, it must be verified that the recipient has the right and the need for the information. Only the information necessary for the required purpose is disclosed.