



Welcome! Thank you for choosing Halcyon Dermatology

Your health care needs are our most important priority. Our goal is to be available and responsive to your needs, and to provide Best in Class medical care for every patient. The following information is provided to introduce you to our practice and help you plan your office visits. Please let us know if you have any questions or would like additional information.

- Office hours are 9am-4:30pm Monday through, Thursday and 9am-1pm on Fridays.
- Please call (949) 266-0216 during regular office hours to schedule an appointment.
- Our office does not provide childcare supervision during appointments. No children under age 12 may be left unaccompanied in the waiting room.
- You will receive a text and/or email prior to your visit to confirm your appointment.
- If you are unable to keep an appointment, please call the office in advance. After hours, you may leave a voicemail.
- **Our specialty practice has a “No Show” fee of \$50** which is charged if you do not cancel 24 hours in advance as permitted by your insurance. We understand things may come up unexpectedly; an exception will be made in case of an emergency. More than 3 no shows or late cancellations may result in dismissal from our practice.
- If you are running late for an appointment, please call our office as we may be able to accommodate your arrival with our schedule. If you are more than 10 minutes late, your appointment may need to be rescheduled as a courtesy to our other patients.
- If you need to contact the physician after hours, an on-call physician will be notified and respond to your call. Please call 911 in case of any emergency.
- Please bring a photo ID and your medical insurance card on your first visit as part of our privacy/identify theft program.
- Halcyon Dermatology maintains compliance with federal and state HIPAA privacy laws. If you would like health information released to yourself or to another person, you must sign a HIPAA release identifying the individual to whom you want information released.
- Co-pays and deductibles are due at the time of your appointment. Bills are payable within 30 days of receipt. We bill insurance on your behalf. However, the balance due is your responsibility.
- Our practice uses an electronic medical record system, and you may register for the Patient Portal to access your medical record information, lab tests, and physician visit notes.
- Once you are a registered patient, you may communicate electronically with Halcyon Dermatology using the Patient Portal or Klara secure text messaging. Please call the office if you have a problem, need help, or have an urgent matter.
- Our office does not permit photography, video, or audio recording in the office.
- We offer telemedicine visits for your convenience when applicable.
- Our practice will need to re-establish care as a new patient if you are not seen for two consecutive years.
- Our practice maintains high standards of excellence and integrity from our staff; we strive to treat each patient with courtesy, respect, and mutual trust. We maintain a zero tolerance for inappropriate behavior on the phone and in the office.
- Please refrain from speaking on your mobile phone while in the exam and waiting rooms. You may forfeit your appointment if you are on the phone when we are ready to start your visit.

We look forward to providing you with the quality medical services to support your health care needs. Wishing you the best of health.

I have reviewed the information above, understand, and was offered the opportunity to ask questions.

X

Patient Signature

Patient Name

Date



PATIENT INFORMATION

Date: _____

Name: _____
Last First M.I.

Address: _____
Street City State Zip

Please list your preferred phone numbers where we are authorized to contact you and leave a message:

Phone: 1. (____) _____ 2. (____) _____ 3. (____) _____

Circle one: HOME/CELL CELL/WORK CELL/WORK

Date of Birth: _____ **Sex:** M F **Social Security Number:** _____

Emergency Contact Name: _____ **Phone:** _____ **Relationship:** _____
Do you have a **POA** (Power of Attorney)? YES NO **Name:** _____ **Relationship:** _____

Marital Status: Single Married Divorced Widowed Legally Separated

Patient Race: White Hispanic Asian Black/African American Other: _____

Ethnicity: Hispanic Non-Hispanic **Preferred Language:** English Spanish Other: _____

Employment Status: Full Time Part-Time Self-Employed Retired

Employer Name: _____

Employer Address: _____
Street City State Zip

Primary Care Physician: _____ **Telephone:** _____

How did you find us? Internet Insurance Other _____
 Physician (Name: _____) Family/Friend (Name: _____)

Insurance Information Insurance Name: _____
ID Number: _____ Group Number: _____
Please check one: Self Pay (no insurance) Patient IS the Policy Holder Patient IS NOT the policy holder
If the above named patient is not the primary policy holder, please fill out the following:
SUBSCRIBER/PRIMARY POLICY HOLDER INFORMATION:
Name: _____
Last First M.I.
Date of Birth: _____ **Social Security Number:** _____ **Sex:** M F
Address: _____
Street City State Zip
Telephone: _____
(____) _____ (____) _____ (____) _____
Home Mobile Work ext

Name: _____ Date: _____
 Date of Birth: _____ Sex: M F Referring Physician: _____
 Reason for Visit: _____
 Pharmacy Name & Address/Cross streets: _____ Pharmacy Phone: _____



Medications and Over the Counter meds/supplements:

Dose	Frequency
_____	_____
_____	_____
_____	_____

Do you have an Advanced Care plan? Yes No
 If Yes, name of POA or decision maker: _____

Allergies: Please list any medication allergies that you have.

Please indicate if you have had any of these conditions.

	Notes
<input type="checkbox"/> Basal Cell Carcinoma	_____
<input type="checkbox"/> Squamous Cell Carcinoma	_____
<input type="checkbox"/> Malignant Melanoma	_____
<input type="checkbox"/> Actinic Keratoses	_____
<input type="checkbox"/> Abnormal Moles	_____
<input type="checkbox"/> Other suspicious lesions	_____
<input type="checkbox"/> Other skin condition	_____

Alerts:
 If female, are you pregnant, nursing, or think you may be pregnant?
Y N
 If female, are you planning a future pregnancy? Y N

Are you allergic to:
 Latex Yes No
 Lidocaine Yes No
 Adhesive Tape Yes No
 Bee Stings Yes No

Do you have a history of cold sores? Yes No
 Do you have a history of fainting or feeling faint with needles?
Yes No
 Do you have a pacemaker?
Yes No
 Are you on a blood thinner medication? Yes No

Social history
 Do you drink alcohol? Yes No
 If Yes, how many times in the past year have you had more than 4 drinks in a day? _____
 Do you use any recreational drugs?
Yes No
 Do you smoke? No Yes
 Packs per day _____
 Smoking start date: _____
 end date: _____
 [Staff note: Enter into MIPS]

Occupation: _____

Have you received the following vaccines?:
 Covid Vaccine No Yes _____ (Date)

Past Medical History

Asthma/COPD/Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding disorder/blood clot	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Crohn's/ulcerative colitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
High blood pressure/cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Joint replacement/ artificial heart valve	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures/Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other	_____

Patient Surgical History: Please list any surgeries and/or hospitalizations including dates: none

Patient Family History: please list any family history of skin disease, cancers, or other diseases:

Review of Systems

Do you have any of these symptoms?

- General**
 Weight change Yes No
 Fatigue/energy loss Yes No
 Fevers Yes No
 Heat/cold intolerance Yes No
 Night sweats Yes No
- Immune**
 Frequent infections Yes No
 Swollen glands Yes No
- Eyes**
 Light sensitivity Yes No
 Blindness/loss of vision Yes No
- Skin**
 Rash Yes No
 Itching Yes No
 Change in hair or nails Yes No
- Ear/Nose/Throat**
 Sinus Problems Yes No
 Trouble swallowing Yes No
 Changes in voice Yes No
- Digestive**
 Abdominal pain Yes No
 Heartburn or ulcers Yes No
 Loss of appetite Yes No
 Nausea or vomiting Yes No
 Constipation or Diarrhea Yes No
- Heart**
 Murmur Yes No
 Chest pain Yes No
 Irregular heart beat Yes No
 Swelling in feet Yes No
- Respiratory**
 Wheezing Yes No
 Shortness of breath Yes No
- Bladder**
 Frequent urination Yes No
 Painful urination Yes No
 Bladder leakage Yes No
- Reproductive**
 Menstrual problems Yes No
 Miscarriages Yes No
- Hematologic**
 Anemia Yes No
 Bleed or bruise easily Yes No
 Blood clots Yes No
- Neurologic**
 Headaches/migraines Yes No
 Dizziness /Fainting Yes No
 Numbness/tingling Yes No
- Psychiatric**
 Mood changes Yes No
 Depression Yes No
 Anxiety/nervousness Yes No



Patient Name: _____ Patient DOB: _____

Signer's Name: _____ Relationship (if not signed by patient): _____

All Patients - Medication Authority

I understand and give my consent for Halcyon Dermatology to retrieve/review my medication history. I understand this will become part of my medical record. A medication history is a list of medicines that all my healthcare providers have recently prescribed. It is collected from a variety of sources including: a patient's pharmacy, health plans, and other healthcare providers. Without an accurate medication history, providers at Halcyon Dermatology will not be able to safely prescribe any medications for you or perform any procedures.

XSigned: _____ Date: _____

All Patients - Privacy and Open Payments Notice

(Please view Privacy and Open Payments Notices here: <https://www.halcyonderm.com/portal/>)

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices and Open Payment Notice, and a copy of any amended Notice of Privacy Practices will be available at each appointment.

XSigned: _____ Date: _____

All Patients - Financial Policy

I have read and understand the financial policy statement. I agree to make in-full prompt payment when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered. Further, I authorize payment directly to Halcyon Dermatology under the terms of my policy. This authorization is valid until revoked in writing. The SIGNER must complete THEIR OWN information here (if different from the patient):

XSigned: _____ Date: _____

Medicare Patients Only – Financial Policy

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. This authorization is valid until revoked in writing.

XSigned: _____ Date: _____



Patient Name: _____ Patient DOB: _____

Signer's Name: _____ Relationship (if not signed by patient): _____

Medical Records Consent

I consent to the use of HIPAA compliant photography, scribes, digital scribes, and/or audio recordings to generate my medical record. Audio recordings are archived and deleted after note generation is completed.

XSigned: _____ Date: _____

Please list all persons(family/friends) to whom your protected health information may be disclosed other than yourself.

I authorize the release of my information to the named persons.

Name: _____ Relationship/Phone _____

Name: _____ Relationship/Phone _____

Name: _____ Relationship/Phone _____

XSigned: _____ Date: _____

Would you like to receive emails regarding cosmetic practice specials such as treatments and products?

yes no