



BEACH CITIES DERMATOLOGY

520 NORTH PROSPECT AVENUE, SUITE 302 - REDONDO BEACH, CALIFORNIA 90277 (310) 798-1515
3831 HUGHES AVENUE, SUITE 504B - CULVER CITY, CALIFORNIA 90232 (310) 204 - DERM
827 DEEP VALLEY DRIVE, SUITE 101 - ROLLING HILLS ESTATES, CALIFORNIA 90274 (310) 265-5515
500 PACIFIC COAST HIGHWAY, SUITE 212, SEAL BEACH, CA 90740 (562) 431-8554
5525 ETIWANDA AVENUE, SUITE 308, TARZANA, CA 91386 (818)705-2901
40731 BIG BEAR BLVD. - BIG BEAR LAKE, CALIFORNIA 92315 (909) 866 - 8688

PATIENT INFORMATION PLEASE PRINT

Patient's Name: _____ Date of Birth: _____ Age: _____

Street Address _____ Apt #: _____ City _____ State _____ Zip _____

P. O Box _____ City _____ State _____ Zip _____ + 4 _____

Home Telephone:(____)____ - _____ Cell Phone: (____)____ - _____

Male: q Female: q Ht: ___' ___" Wt.: ___pounds Social Security Number: _____ - ____ - ____

Single: u Married: u Widowed: u Divorced: u

Employer: _____ (F/T P/T unemployed) Work Phone:(____)____ - _____

Address: _____
STREET CITY STATE ZIP

Drivers License #: _____ Primary Language spoken: _____

Occupation: _____ E-Mail Address: _____

Ethnicity: White Hispanic African American American Indian Asian Pacific Islander Other (circle one)

uuuuuuuuu REFERRAL INFORMATION uuuuuuuuuuuuuuu

Who referred you to this office? _____
Have you seen another doctor for this problem? Yes q No q Name: _____

CO PAYS, DEDUCTIBLES AND COINSURANCE AMOUNTS ARE DUE AT THE TIME OF SERVICE. IF YOU HAVE QUESTIONS ABOUT YOUR COVERAGE PLEASE ASK BEFORE SERVICES ARE RENDERED. If your insurance coverage is not effective or does not cover certain services performed you are financially responsible for these services rendered. Some insurance plans have a separate deductible for any surgical procedures that are done in a doctor's office. I understand the failure to make the required copayment / deductible at the time of service will result in a \$25 service charge to my account.

I have read the above and understand my financial responsibility for services rendered in this office.
I understand that any appointments not cancelled or rescheduled with at least 24 hours notice will incur a \$30 service charge to my account.
I understand that any account turned over for collection proceedings will incur a fee of \$25.00

SIGNATURE: _____ DATE: _____

GUARANTOR/INSURED INFORMATION

Name of insured: _____ Male/Female Relationship to patient: _____
Address: _____ Date of Birth: _____
SS#: _____
Employer: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Telephone:(____)____ - _____
Relationship: _____



BEACH CITIES DERMATOLOGY

520 NORTH PROSPECT AVENUE, SUITE 302 - REDONDO BEACH, CALIFORNIA 90277 (310) 798-1515
 3831 HUGHES AVENUE, SUITE 504B - CULVER CITY, CALIFORNIA 90232 (310) 204 - DERM
 827 DEEP VALLEY DRIVE, SUITE 101 - ROLLING HILLS ESTATES, CALIFORNIA 90274 (310) 265-5515
 500 PACIFIC COAST HIGHWAY, SUITE 212, SEAL BEACH, CA 90740 (562) 431-8554
 5525 ETIWANDA AVENUE, SUITE 308, TARZANA, CA 91386 (818)705-2901
 40731 BIG BEAR BLVD. - BIG BEAR LAKE, CALIFORNIA 92315 (909) 866 - 8688

HEALTH QUESTIONNAIRE

Patient Name: _____

Reason for Visit: _____

MEDICATIONS

List all medications that you are using...INCLUDE OVER-THE-COUNTER PILLS, CREAMS & VITAMINS ALSO!

NAME	STRENGTH	HOW OFTEN	NAME	STRENGTH	HOW OFTEN

ALLERGIES

List all reactions to MEDICINES & DRUGS - Also include reactions to FOODS & OTHER ALLERGENS.

NAME	TYPE OF REACTION	NAME	TYPE OF REACTION	NAME	TYPE OF REACTION

HOSPITALIZATIONS

List all hospitalizations including surgeries, operations & medical illnesses.

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

MEDICAL HISTORY

Draw a **BIG CIRCLE** around YOUR current problems below.

UNDERLINE if there is a family history of any of these problems.

Check (✓) box to indicate if you have had of any other symptoms or diseases and write in age of onset.

- CANCER
- ABNORMAL MOLES OR DYSPLASIA
- SQUAMOUS OR BASAL CELL CANCER
- ECZEMA
- PSORIASIS
- HERPES
- SYPHILIS
- GENITAL WARTS
- SCARS EASILY
- DIABETES
- DEPRESSION
- MENTAL ILLNESS
- HAY FEVER
- GLAUCOMA
- JAUNDICE
- COLITIS
- MELANOMA
- FREQUENT BURNS
- HIVES
- GONORRHEA
- CHLAMYDIA
- MOLLUSCUM
- HAIR LOSS
- THYROID DISEASE
- ASTHMA
- CATARACTS
- HEPATITIS
- ULCERS

- ARTHRITIS
- ANEMIA
- SEIZURES
- HEART PROBLEMS OR MURMUR
- MITRAL VALVE PROLAPSE
- HIGH BLOOD PRESSURE
- KIDNEY PROBLEMS OR STONES
- RECENT WEIGHT LOSS (HOW MUCH?)
- OTHER: _____
- ALCOHOL - OZ. / WK. _____
- SMOKING - CIG. / DAY _____ # YEARS _____
- COFFEE / TEA - CUPS / DAY _____
- F E M A L E S
- REGULAR MENSTRUAL PERIODS
- NUMBER OF: _____ PREGNANCIES _____
- _____ I / M E D I T U S

MISCARRIAGES _____
 BIRTH CONTROL METHOD _____

Check (✓) box if you used the back of this sheet for additional space.



**BEACH CITIES DERMATOLOGY MEDICAL CENTER/ BIG BEAR
DERMATOLOGY/PALOS VERDES DERMATOLOGY/TARZANA
DERMATOLOGY/CULVER MARINA/WEST LA DERMATOLOGY/BEACH
DERMATOLOGY IN SEAL BEACH**

520 N. Prospect Avenue, Suite 302, Redondo Beach, CA 90277
Phone: 310.798.1515 FAX: 310.798.3131 email: janis@beachcitiesderm.com

Notice of Privacy Practices

I, _____, acknowledge that I have received the Notice of Privacy Practices.

Signature

Date