WILLIAM J WICKWIRE M.D. INC
BEACH CITIES DERMATOLOGY 520 NORTH PROSPECT AVENUE, SUITE 302 - REDONDO BEACH, CALIFORNIA 90277
BEACH CITIES DERMATOLOGY OF WEST LA 3831 HUGHES AVENUE, SUITE 504B - CULVER CITY, CALIFORNIA 90232
PALOS VERDES DERMATOLOGY 827 DEEP VALLEY DRIVE, SUITE 101 - ROLLING HILLS ESTATES, CALIFORNIA 90274
BEACH DERMATOLOGY SEAL BEACH 500 PACIFIC COAST HIGHWAY, SUITE 212, SEAL BEACH, CA 90740
BIG BEAR DERMATOLOGY 40731 BIG BEAR BLVD. - BIG BEAR LAKE, CALIFORNIA 92315
HUNTINGTON BEACH DERMATOLOGY 16897 ALGONQUIN STREET, SUITE 106 HUNTINGTON BEACH, CA 92649
DERMATOLOGY AND LASER CENTER OF IRVINE 16300 SAND CANYON AVENUE, SUITE 612 IRVINE, CA 92618

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: (**____**)**______ **-**__________ Please check preferred number

Male: ❑ **Female:** ❑ **Ht:**___**'**___**"** **Wt.:**____**pounds** **Social Security Number:**_______**-**____**-**_____

Single: ❑ **Married:** ❑ **Widowed:** ❑ **Divorced:** ❑

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**

---------------- **REFERRAL INFORMATION** -----------------

How did you hear about our office? **Please check one:** ❑ **Beach Reporter** ❑ **Easy Reader** ❑ **Facebook** ❑ **South Bay Magazine** ❑ **Insurance Book** ❑ **Google** ❑ **Yelp** ❑ **Supermedia** ❑ **Yellow Pages** ❑ **Other** ______________________

Have you seen another doctor for this problem? Yes ❑ No ❑ 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 $50 service charge to my account.
I understand that any account turned over for collection proceedings will incur a fee of $25.00
I understand that if a prior authorization is necessary for medications or medical services, there may be a fee of $25.00
As a service to our clients, we provide a courtesy appointment reminder call placed using a prerecorded message. By signing below, you consent to receiving such calls.

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, CA 90277 (310) 798-1515
3831 HUGHES AVENUE, SUITE 504B - CULVER CITY, CA 90232 (310) 204 - 3376
827 DEEP VALLEY DRIVE, SUITE 101 - ROLLING HILLS ESTATES, CA 90274 (310) 265-5515
500 PACIFIC COAST HIGHWAY, SUITE 212, SEAL BEACH, CA 90740 (562) 431-8554
16300 SAND CANYON AVENUE, SUITE 612 IRVINE, CA 92618 (949)753-1001
40731 BIG BEAR BLVD. - BIG BEAR LAKE, CA 92315 (909) 866 – 8688
16897 ALGONQUIN STREET, SUITE 106 HUNTINGTON BEACH, CA 92649 (714) 840-2447

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
PREFERRED PHARMACY		PHONE		ADDRESS	

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

GLAUCOMA CATARACTS
JAUNDICE HEPATITIS
COLITIS ULCERS
ARTHRITIS GOUT
ANEMIA BRUISE EASILY
SEIZURES STROKE
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 ______________

FEMALES

REGULAR MENSTRUAL PERIODS
NUMBER OF: PREGNANCIES ______
LIVE BIRTHS ________
MISCARRIAGES _____
BIRTH CONTROL METHOD _______________

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

WILLIAM J WICKWIRE M.D. INC
BEACH CITIES DERMATOLOGY 520 NORTH PROSPECT AVENUE, SUITE 302 - REDONDO BEACH, CALIFORNIA 90277
BEACH CITIES DERMATOLOGY OF WEST LA 3831 HUGHES AVENUE, SUITE 504B - CULVER CITY, CALIFORNIA 90232
PALOS VERDES DERMATOLOGY 827 DEEP VALLEY DRIVE, SUITE 101 - ROLLING HILLS ESTATES, CALIFORNIA 90274
BEACH DERMATOLOGY SEAL BEACH 500 PACIFIC COAST HIGHWAY, SUITE 212, SEAL BEACH, CA 90740
BIG BEAR DERMATOLOGY 40731 BIG BEAR BLVD. - BIG BEAR LAKE, CALIFORNIA 92315
HUNTINGTON BEACH DERMATOLOGY 16897 ALGONQUIN STREET, SUITE 106 HUNTINGTON BEACH, CA 92649
DERMATOLOGY AND LASER CENTER OF IRVINE 16300 SAND CANYON AVENUE, SUITE 612 IRVINE, CA 92618

Beach Cities Dermatology Medical Center/ Big Bear Dermatology/Palos Verdes Dermatology/Culver Marina/West LA Dermatology/Beach Dermatology in Seal Beach/Huntington Beach Dermatology/dermatology and laser group of Irvine

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

OPEN PAYMENT DATABASE

“The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.”

______________________________ ___________________
Signature **Date**

WILLIAM J WICKWIRE M.D. INC
BEACH CITIES DERMATOLOGY 520 NORTH PROSPECT AVENUE, SUITE 302 - REDONDO BEACH, CALIFORNIA 90277
BEACH CITIES DERMATOLOGY OF WEST LA 3831 HUGHES AVENUE, SUITE 504B - CULVER CITY, CALIFORNIA 90232
PALOS VERDES DERMATOLOGY 827 DEEP VALLEY DRIVE, SUITE 101 - ROLLING HILLS ESTATES, CALIFORNIA 90274
BEACH DERMATOLOGY SEAL BEACH 500 PACIFIC COAST HIGHWAY, SUITE 212, SEAL BEACH, CA 90740
BIG BEAR DERMATOLOGY 40731 BIG BEAR BLVD. - BIG BEAR LAKE, CALIFORNIA 92315
HUNTINGTON BEACH DERMATOLOGY 16897 ALGONQUIN STREET, SUITE 106 HUNTINGTON BEACH, CA 92649
DERMATOLOGY AND LASER CENTER OF IRVINE 16300 SAND CANYON AVENUE, SUITE 612 IRVINE, CA 92618

I, ______________________________________ hereby state that all medical information may be released or discussed with the following:

(Please check all that apply, and list names/phone numbers as appropriate)

Answer machine at phone number _______________________________________

- ❑ **Spouse ____**
- ❑ **Mother ____**
- ❑ **Father ____**
- ❑ **Sister (s)____**
- ❑ **Brother (s)____**
- ❑ **Son (s)____**
- ❑ **Daughter(s)____**
- ❑ **Caregiver ____**
- ❑ **Other ____**

- ❑ **NO ONE ELSE BUT PATIENT**

I have an advance care plan in place YES ❑ NO ❑

My advanced care decision maker is: __________________________ DECLINE TO DISCLOSE ❑

In the event that I would need any or all medical information released to me, I understand that I can request that it be emailed to me at _____________________________ but I do realize that it would not be considered an "encrypted or secure" method.

Patient Signature: ____

Date: ____

WILLIAM J WICKWIRE M.D. INC

BEACH CITIES DERMATOLOGY 520 NORTH PROSPECT AVENUE, SUITE 302 - REDONDO BEACH, CALIFORNIA 90277
BEACH CITIES DERMATOLOGY OF WEST LA 3831 HUGHES AVENUE, SUITE 504B - CULVER CITY, CALIFORNIA 90232
PALOS VERDES DERMATOLOGY 827 DEEP VALLEY DRIVE, SUITE 101 - ROLLING HILLS ESTATES, CALIFORNIA 90274
BEACH DERMATOLOGY SEAL BEACH 500 PACIFIC COAST HIGHWAY, SUITE 212, SEAL BEACH, CA 90740
BIG BEAR DERMATOLOGY 40731 BIG BEAR BLVD. - BIG BEAR LAKE, CALIFORNIA 92315
HUNTINGTON BEACH DERMATOLOGY 16897 ALGONQUIN STREET, SUITE 106 HUNTINGTON BEACH, CA 92649
DERMATOLOGY AND LASER CENTER OF IRVINE 16300 SAND CANYON AVENUE, SUITE 612 IRVINE, CA 92618

Patient Name: ______________________________

William J Wickwire, M.D. Inc., also known as Beach Cities Dermatology / Beach Cities Dermatology Medical Center of West L.A./ Big Bear Dermatology/Palos Verdes Dermatology / Long Beach Dermatology / Beach Cities Dermatology Medical Associates (Seal Beach office), Huntington Dermatology / Beach Cities Dermatology of Costa Mesa/Newport/ Dermatology and Laser Group of Irvine, does accept Medicare assignment, but does not guarantee participation in your supplemental plan, if any.

William J Wickwire, M.D. Inc., also known as Beach Cities Dermatology/Beach Cities Dermatology Medical Center of West L.A./ Big Bear Dermatology/Palos Verdes Dermatology/ Long Beach Dermatology/Beach Cities Dermatology Medical Associates (Seal Beach office)/ Huntington Dermatology / Beach Cities Dermatology of Costa Mesa/Newport/ Dermatology and Laser Group of Irvine does not participate in any HMO insurance plans.

It is the responsibility of the patient to know his/her individual insurance policy benefits, limitations and coverage, including participation of physicians in your plan. We will do our best to get accurate benefit quotes from your insurance carriers in which to base your payment at the time of service.

Ultimately, all charges are the responsibility of the patient and/or guarantor.

____
Initial

MULTIPLE MISSED OR CANCELLED APPOINTMENTS MAY RESULT IN A LOSS OF APPOINTMENT ACCESS

____
Initial

MEDICARE PATIENTS

I request that the payment of authorized Medicare benefits and any other medical benefits be made on my behalf to William J Wickwire, M.D. Inc., also known Beach Cities Dermatology/Beach Cities Dermatology Medical Center of West L.A./ Big Bear Dermatology/Palos Verdes Dermatology/Long Beach Dermatology/Beach Cities Dermatology Medical Associates (Seal Beach office), Huntington Dermatology /Beach Cities Dermatology of Costa Mesa/Newport, / Dermatology and Laser Group of Irvine and for any services furnished to me by William J. Wickwire, M.D., Neal M. Ammar, M.D., Fariba Seraj, RNP/PA-C, Geover Fernandez, M.D., Jeffrey Lander, M.D., Erik Sorenson, P.A., Pascal Ferzli, M.D, and Desirae Macias, PA. I understand my signature requests that payments be made and authorizes release of any information necessary to pay the claim.

Signature: ____ Date:____________________

The patient is responsible for payment of the deductible, co-insurance, and non-covered services regardless of other coverage (excluding Medi-Cal). Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

Signature: ____ Date:_____________________

PRIVATE INSURANCE

I request that the payment of authorized insurance benefits and any other medical benefits be made on my behalf to William J Wickwire, M.D. Inc., also known Beach Cities Dermatology/Beach Cities Dermatology Medical Center of West L.A./ Big Bear Dermatology/Palos Verdes Dermatology/Long Beach Dermatology/Beach Cities Dermatology Medical Associates (Seal Beach office), Huntington Dermatology /Beach Cities Dermatology of Costa Mesa/Newport, / Dermatology and Laser Group of Irvine and for any services furnished to me by William J. Wickwire, M.D., Neal M. Ammar, M.D., Fariba Seraj, RNP/PA-C, Geover Fernandez, M.D., Jeffrey Lander, M.D., Erik Sorenson, P.A., Pascal Ferzli, M.D, and Desirae Macias, PA. I understand my signature requests that payments be made and authorizes release of any information necessary to pay the claim.

Signature:____ Date:____________________

The patient is responsible for payment of the deductible, co-payments, coinsurance, and non-covered services.
Deductibles, copays and coinsurances are due at the time of service

Signature:____ Date:____________________

PATIENTS WITHOUT INSURANCE OR IN NON-PARTICIPATING PLANS:

I understand that payment, in full, is due at the time of service unless prior arrangements have been made.

Signature:____ Date:__________________

WILLIAM J WICKWIRE M.D. INC

BEACH CITIES DERMATOLOGY 520 NORTH PROSPECT AVENUE, SUITE 302 - REDONDO BEACH, CALIFORNIA 90277
BEACH CITIES DERMATOLOGY OF WEST LA 3831 HUGHES AVENUE, SUITE 504B - CULVER CITY, CALIFORNIA 90232
PALOS VERDES DERMATOLOGY 827 DEEP VALLEY DRIVE, SUITE 101 - ROLLING HILLS ESTATES, CALIFORNIA 90274
BEACH DERMATOLOGY SEAL BEACH 500 PACIFIC COAST HIGHWAY, SUITE 212, SEAL BEACH, CA 90740
BIG BEAR DERMATOLOGY 40731 BIG BEAR BLVD. - BIG BEAR LAKE, CALIFORNIA 92315
HUNTINGTON BEACH DERMATOLOGY 16897 ALGONQUIN STREET, SUITE 106 HUNTINGTON BEACH, CA 92649
DERMATOLOGY AND LASER CENTER OF IRVINE 16300 SAND CANYON AVENUE, SUITE 612 IRVINE, CA 92618

Arbitration Agreement

Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term “patient” herein shall mean the mother and the mother’s expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician’s partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Procedures and Applicable Law: A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party’s pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party’s own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code
Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator. General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration. Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition. Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

____
Patient’s or Patient Representative’s Initials

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy. NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Print Patient’s Name ____

By: ___________________________________ __________
Patient’s or Patient Representative’s Signature

(Date) ______________________

William J Wickwire, M.D. Inc, APC DBA Beach Cities Dermatology Medical Center

By: ____________________________________ _________
Physician’s or Authorized Representative’s Signature

(Date) ________________________
(If Representative, Print Name and Relationship to Patient) Medical Group or Association Name A signed copy of this document is to be given to Patient. Original is to be filed in Patient’s medical records.