



# 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  
 275 VICTORIA STREET SUITE 2H COSTA MESA, CA 92627 (949) 631-1051  
 40731 BIG BEAR BLVD. - BIG BEAR LAKE, CA 92315 (909) 866 - 8688  
 16897 ALGONQUIN STREET, SUITE A HUNTINGTON BEACH, CA 92649 (714) 840-2447

## 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: \_\_\_\_\_



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## 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                    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 \_\_\_\_\_

#### F E M A L E S

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.



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### MAIN OFFICE

520 N. Prospect Avenue, Suite 302, Redondo Beach, CA 90277  
Phone: 310.798.1515 • FAX: 310.798.3131 • Email: [janis@beachcitiesderm.com](mailto:janis@beachcitiesderm.com)

## Notice of Privacy Practices

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

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Signature

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Date



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I, \_\_\_\_\_ hereby state that my lab/test results may be given to any of 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: \_\_\_\_\_



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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 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 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., Linda Globerman, M.D., Jeffrey Lander, M.D., Erik Sorenson, P.A., Pascal Ferzli, M.D. 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 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 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., Linda Globerman, M.D., Jeffrey Lander, M.D., Erik Sorenson, P.A., Pascal Ferzli, M.D. 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: \_\_\_\_\_