WALLACH DERMA CENTER
Dermatology, Cosmetic Surgery and Medi-spa

925.837.8848
400 El Cerro Blvd.,
Ste. 204,
Danville, CA 94526

Date: _____

PATIENT INFORMATION

Name _____ **SS#** _____
LAST FIRST MIDDLE INITIAL

Date of Birth _____ **Gender** ❑ Male ❑ Female **Marital Status** ❑ Single ❑Married ❑Divorced ❑Widowed

Address _____
STREET CITY STATE ZIP

Alternate Address _____
STREET CITY STATE ZIP

Phone *(check ☑ preferred contact number)*:
Home❑ _____ **Cell**❑ _____ **Work**❑ _____

e-Mail _____ **Do you authorize us to send you office-related information by email?** ❑Yes ❑No

Employer_____ **Employer's Address** _____
STREET CITY STATE ZIP

Primary Care Physician _____ **PCP Phone** _____

_____
STREET SUITE CITY STATE ZIP

Referring Physician ❑PCP or ❑Other Physician Name_____ **Phone** _____

If not referred by a physician, how did you hear about us? ❑Magazine ❑WebSite _____ ❑Phone Book ❑Friend/Family _____

Pharmacy _____ **Phone** _____

Address _____
CROSSROADS CITY STATE ZIP

PERSON RESPONSIBLE FOR PAYMENT

Last Name: _____ **First:** _____ **MI:** _____ **SS#:** _____

Relationship to Patient: ❑Spouse ❑Parent ❑Legal Guardian **Date of Birth:** _____/_____/_____

Address: _____ **City:**_____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

INSURANCE *Please present insurance card(s) with this completed form*

Primary Insurance Subscriber: _____ **Insurance Company:**_____

Date of Birth: _____/_____/_____ **Group #:** _____ **Social Security #:** _____

Secondary Insurance Subscriber: _____ **Insurance Company:** _____

Date of Birth: _____/_____/_____ **Group #:** _____ **Social Security #:** _____

EMERGENCY CONTACT

Name: _____ _____ **Phone:** (____) _____-_____ **Relationship:** _____

Name: _____ _____ **Phone:** (____) _____-_____ **Relationship:** _____

PARENT/LEGAL GUARDIAN (IF UNDER 18 YEARS OLD)

Name: _____ **Phone:** (____) _____-_____ **Relationship:** _____

WALLACH DERMA CENTER
Dermatology, Cosmetic Surgery and Medi-spa

Patient Name: _____

DOB: _____

These questions are included to comply with new Federal Health guidelines -- we are required to ask for this information.	**Ethnicity** *(check one)*	❑ Hispanic or Latino	❑ Not Hispanic or Latino	❑Declined or Unspecified
	Race *(check one)*	❑ American Indian/Alaskan Native	❑ Asian	❑ Native Hawaiian/Other Pacific Island
		❑ Black/African American	❑ White	❑Declined or Unspecified
	Preferred Language *(check one)*	❑ English	❑ Spanish	❑Declined or Unspecified

MEDICATIONS

(please list all prescription & over-the-counter medications you are taking, including herbs, vitamins & supplements – a long with the dosage)

If you currently DO NOT TAKE ANY MEDICATIONS, check this box: ❑

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

MEDICATION ALLERGIES/REACTIONS *(please list medication and associated allergic reaction)*

If you have NO KNOWN MEDICATION ALLERGIES, check this box: ❑

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

SMOKING STATUS *(check one)*

❑ Never been a smoker ❑ Former smoker ❑ Current sometimes smoker ❑ Current every day smoker

CURRENT MEDICAL CONDITION

REASON FOR TODAY'S VISIT:

APPOINTMENT REMINDERS, LABORATORY RESULTS, AND BILLING ISSUES

Please check how you would like to be notified:

❑ Home Telephone number:_____

❑ Cell Phone number:_____

❑ Work Number:_____

May we leave a detailed message?

❑Yes ❑No

You may discuss any of my medical information with the following individuals:

1._____

NAME RELATIONSHIP TELEPHONE

2._____

NAME RELATIONSHIP TELEPHONE

Patient Name: _____ Patient Signature: _____

PLEASE PRINT CLEARLY

How much do you weigh? _____lbs

What is your height? _____inches

Patient Name: _____

DOB: _____

Past Medical History: (please check all that apply)

❑ Anxiety	❑ Depression	❑ Leukemia
❑ Arthritis	❑ Diabetes	❑ Lung Cancer
❑ Artificial joints	❑ End Stage Renal Disease	❑ Lymphoma
❑ Asthma	❑ GERD	❑ Pacemaker
❑ Atrial fibrillation	❑ Hearing Loss	❑ Prostate Cancer
❑ BPH	❑ Hepatitis	❑ Radiation Treatment
❑ Bone Marrow Transplantation	❑ Hypertension	❑ Seizures
❑ Breast Cancer	❑ HIV/AIDS	❑ Stroke
❑ Colon Cancer	❑ Hypercholesterolemia	❑ Valve Replacement
❑ COPD	❑ Hyperthyroidism	❑ None
❑ Coronary Artery Disease	❑ Hypothyroidism	❑

❑ Other _____

Past Surgical History: (please check all that apply)

❑ Appendix Removed	❑ Mechanical Valve Replacement	❑ Prostate Removed: Prostate Cancer
❑ Bladder Removed	❑ Biological Valve Replacement	❑ Prostate Biopsy
❑ Mastectomy (Right, Left, Bilateral)	❑ Heart Transplant	❑ TURP
❑ Lumpectomy (Right, Left, Bilateral)	❑ Joint Replacement, Knee (Right, Left, Bilateral)	❑ Skin Biopsy
❑ Breast Biopsy (Right, Left, Bilateral)	❑ Joint Replacement, Hip (Right, Left, Bilateral)	❑ Basal Cell Cancer Surgery
❑ Breast Reduction	❑ Joint Replacement within last 2 years	❑ Squamous Cell Carcinoma Surgery
❑ Breast Implants	❑ Kidney Biopsy	❑ Melanoma Surgery
❑ Colectomy: Colon Cancer Resection	❑ Kidney Removed (Right, Left)	❑ Spleen Removed
❑ Colectomy: Diverticulitis	❑ Kidney Stone Removal	❑ Testicles Removed (Right, Left, Bilateral)
❑ Colectomy: IBD	❑ Kidney Transplant	❑ Hysterectomy: Fibroids
❑ Gallbladder Removed	❑ Ovaries Removed: Endometriosis	❑ Hysterectomy: Uterine Cancer
❑ Coronary Artery Bypass	❑ Ovaries Removed: Cyst	❑ None
❑ PTCA	❑ Ovaries Removed: Ovarian Cancer	

❑ Other _____

Skin Disease History: (please check all that apply)

❑ Acne	❑ Dry Skin	❑ Poison Ivy
❑ Actinic Keratoses	❑ Eczema	❑ Precancerous Moles
❑ Asthma	❑ Flaking or Itchy Scalp	❑ Psoriasis
❑ Basal Cell Skin Cancer	❑ Hay Fever/Allergies	❑ Squamous Cell Skin Cancer
❑ Blistering Sunburns	❑ Melanoma	❑ None

❑ Other _____

Patient Name: _____

DOB: _____

Do you wear Sunscreen? ❑Yes ❑No If yes, what SPF? _____

Do you tan in a tanning salon? ❑Yes ❑No

Do you have a family history of Melanoma? ❑Yes ❑No

If yes, which relative(s)? _____

Cautions: (please check all that apply)

Have you ever had difficulty stopping bleeding? ❑Yes ❑No

Do you require antibiotics prior to a surgical procedure? ❑Yes ❑No

Have you had an artificial joint replacement? ❑Yes ❑No

If yes, when and what body locations? _____

Do you have an artificial heart valve? ❑Yes ❑No

Do you have a pacemaker? ❑Yes ❑No

Do you have a defibrillator? ❑Yes ❑No

Are you pregnant or currently trying to get pregnant? ❑Yes ❑No

Social History: *(Please check all that apply)*

Drug Use ❑No ❑Yes _____ Other_____

Review of Systems: Are you currently experiencing any of the following? (please check ☑Yes or ☑No for the following)

Symptom		Symptom		Symptom	
Abdominal Pain	❑Yes ❑No	Depression	❑Yes ❑No	Seizures	❑Yes ❑No
Anxiety	❑Yes ❑No	Fever or Chills	❑Yes ❑No	Shortness of Breath	❑Yes ❑No
Bleeding Problems	❑Yes ❑No	Headaches	❑Yes ❑No	Sore Throat	❑Yes ❑No
Bloody Stool	❑Yes ❑No	Hay Fever	❑Yes ❑No	Thyroid Problems	❑Yes ❑No
Bloody Urine	❑Yes ❑No	Joint Aches	❑Yes ❑No	Unintentional Weight Loss	❑Yes ❑No
Blurry Vision	❑Yes ❑No	Muscle Weakness	❑Yes ❑No	Wheezing	❑Yes ❑No
Changing Mole	❑Yes ❑No	Neck Stiffness	❑Yes ❑No	Other: _____	❑Yes ❑No
Chest Pain	❑Yes ❑No	Night Sweats	❑Yes ❑No	_____	❑Yes ❑No
Cough	❑Yes ❑No	Rash	❑Yes ❑No	_____	❑Yes ❑No

Patient Name: _____

DOB: _____

AESTHETIC QUESTIONNAIRE

Do you have any moles whose appearance bothers you?	❑Yes ❑No
Have you ever considered removing excessive hair?	❑Yes ❑No
Do you have more wrinkles than you'd like?	❑Yes ❑No
Are you bothered by the redness or the fine vessels on your face?	❑Yes ❑No
Do you have brown sunspots that you'd like to get rid of?	❑Yes ❑No
Did you ever consider removing the excess skin above your eyes?	❑Yes ❑No
Are you bothered by frown lines or deepening furrows?	❑Yes ❑No
Do you have any questions about BOTOX, Restylane, Juviderm or Sculptra?	❑Yes ❑No
Ever wonder about the possibility of removing fat around the abdomen or from the neck?	❑Yes ❑No
Have you ever considered doing something "rejuvenating" to your skin but were scared of surgery?	❑Yes ❑No
Are you interested in a simple way to have your skin glow and also have your make-up go on smoother?	❑Yes ❑No
Are you interested in products to slow down the aging process but are confused by the numerous choices and sometimes misleading advertising?	❑Yes ❑No
Ever considered permanent make-up?	❑Yes ❑No

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.

If you would like to read the complete HIPPA rules, please ask our front desk staff.

Wallach Derma Center
*Patient or Guardian Signature*_____

*Date*_____

In consideration of other patients who need to see us, we ask that you please cancel or reschedule at least 24 hours prior to your scheduled appointment. If you must cancel within 24 hours or do not show for your appointment, a $25 service fee will be charged to your account. Thank you in advance for your understanding.

*Patient or Guardian Signature*_____