



Welcome to our office! Thank you for choosing O.C. Dermatology & Surgery. We are a full-service dermatology practice whose priority is delivering high-quality, ethical care. Our knowledgeable staff aims to create a friendly, positive atmosphere for our patients and takes pride in serving our patients.

At OC Dermatology & Surgery, you will be seen by only board-certified dermatologists. We believe this is essential to delivering high-quality care. All of our doctors (Dr. Soni, Dr. Fulwider, & Dr. Eragi,) are extensively trained in medical, surgical, and cosmetic dermatology. Additionally, Dr. Soni and Dr. Fulwider are highly trained and experienced in Mohs micrographic surgery. We believe in spending the time necessary to educate and provide patients with the highest level of care, thereby maximizing outcomes. When it comes to skin cancers, all our dermatologists are firm believers of early detection by means of routine, thorough skin exams with digital photography and dermoscopy. And when a skin cancer needs to be treated, we do so with skill, compassion, and many times painless (or almost painless) procedures. Artists both in and out of the office, our doctors use their artistic eye both 1) to maximize the cosmetic outcome of reconstructive surgery after skin cancer removal and 2) to help patients achieve a more youthful, healthy look.

Enclosed are the following forms (4) for you to review and complete at your convenience prior to your scheduled appointment: 1) patient registration form; 2) office policies; 3) notice of privacy practices & acknowledgement of receipt; & 4) medical history form.

We kindly ask that you arrive 15 minutes prior to your scheduled appointment time and that you bring 1) the completed forms, 2) your insurance card(s), and 3) an official photo ID (e.g. driver's license). We look forward to seeing you and appreciate the trust you have placed in us regarding your care.

Sincerely,

Orange County Dermatology & Surgery

*Note: Google Maps, Mapquest, and most GPS tracking systems incorrectly map the address.
PLEASE NOTE THE FOLLOWING ACCURATE DIRECTIONS:

From the North

Take the I-405 South
Take the Beach Blvd/CA-39 exit (Exit 16).
Take the 1st ramp toward Huntington Beach.
Turn left onto Center Ave.
Turn right onto Beach Blvd/CA-39
Turn left onto Newman Ave...

From the East

Take Beach Blvd/CA-39 South.
Turn left onto Newman Ave...

From the South

Take the I-405 North
Take the Brookhurst St exit (Exit 14).
Take the Brookhurst St. South ramp.
Turn right onto Talbert Ave.
Turn right onto Beach Blvd/CA-39 North.
Turn right onto Newman Ave...

From the West

Take Beach Blvd/CA-39 North.
Turn right onto Newman Ave...

...Pass the parking structure and brick & glass building on your right-hand side.
Turn right into the hospital parking lot.
You will see the front entrance to the brick & glass building, where we are located.



PATIENT INFORMATION Please present your driver's license at the time of check-in.

Patient Name: _____ Date of Birth ____/____/____

Last First M.I.

Mailing Address: St _____ City _____ State _____ Zip _____

May we mail information related to your care to the mailing address above? Y N

Gender: Male Female Marital Status: Single Married Separated Divorced Widow

Home Phone (____) _____ Preferred May we leave a message with your health information? Y N

Cell Phone (____) _____ Preferred May we leave a message with your health information? Y N

E-mail: _____ May we e-mail you occasional practice or educational updates? Y N

Driver's License # _____ State _____ Social Security # _____-_____-_____

Employer _____ Occupation _____ Work (____) _____ x _____ OK to call? Y N

Employer Address: St _____ City _____ State _____ Zip _____

Spouse: Name _____ Phone (____) _____ May we discuss your health information? Y N

INSURANCE - PRIMARY: Please present insurance card at the time of check-in. No Insurance

Insurance Name _____ Subscriber # _____ Group# _____

Address: St _____ City _____ State _____ Zip _____

Who is the policy holder? Patient Spouse Parent/Guardian If not the patient, please complete INSURED INFO below.

INSURANCE - SECONDARY: Please present insurance card at the time of check-in.

Insurance Name _____ Subscriber # _____ Group# _____

Address: St _____ City _____ State _____ Zip _____

INSURED INFORMATION Please complete if insured is other than the patient (e.g. spouse, parent, guardian).

Name _____ Date of Birth ____/____/____ Social Security _____-_____-_____

Address: St _____ City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____ Gender: Male Female

Employer _____ Occupation _____ Work (____) _____ x _____

Employer Address: St _____ City _____ State _____ Zip _____

PRIMARY CARE PHYSICIAN _____ Phone (____) _____

PHARMACY OF CHOICE _____ Phone (____) _____

St/Cross St _____ City _____ State _____ Zip _____

HOW DID YOU FIND OUT ABOUT US? A) A friend referred me. Who? _____ B) A doctor referred me. Who? _____ C) through my insurance company. How? _____ D) other: _____

EMERGENCY CONTACT (not living with you)

Name _____ Relationship _____ Phone (____) _____

I understand that the physicians are licensed and regulated by the Medical Board of California.

(800) 633-2322 www.mbc.ca.gov

SIGNATURE: Patient Parent Guardian Conservator

(please circle one)

PRINT NAME _____

DATE _____

If the person signing this form is the patient's parent, legal guardian, or conservator, please complete the following:

Name: _____ Date of Birth ____/____/____ Gender: M F

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Reviewed by _____



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that I am aware that a copy of the current notice is posted in the reception area and that a copy of any amended Notice of Privacy Practices will be available at each appointment as well as on the practice website.

Signed: _____

Date: _____

Print Name: _____

Telephone: _____

If not signed by the patient, please indicate relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient

Name and Address of Patient: _____

I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:



Patient Name: _____

Date: _____

Females: Planning on becoming OR currently pregnant? Yes No Breastfeeding? Yes No

ALLERGIES: (e.g. meds, latex, tape)

MEDICATIONS(current):

Review of Systems - Do you currently have or have you previously had any of the following?

Yes	No		Yes	No	SKIN	Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Skin cancer: _____	<input type="checkbox"/>	<input type="checkbox"/>	Easy bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Rashes:
<input type="checkbox"/>	<input type="checkbox"/>	Problematic/slow healing	<input type="checkbox"/>	<input type="checkbox"/>	Keloids / thick scars	<input type="checkbox"/>	<input type="checkbox"/>	Other:

ENT

Glaucoma

Itchy eyes

Ear infections

Sinus trouble

Nosebleeds

Mouth sores

Other: _____

RESPIRATORY

Shortness of breath

Wheezing

Asthma

Bronchitis

Other: _____

CARDIOVASCULAR

Chest pain

High blood pressure

Low blood pressure

Irregular heartbeat

Heart attack

Heart murmur

Cardiac surgery

Mitral valve prolapse

Artificial heart valve

Pacemaker

Phlebitis

High cholesterol

Other: _____

Yes No **Social History:**

Do you drink alcohol?

Do you smoke tobacco?

Do you use IV drugs?

Occupation: _____ Hobbies/leisure activities: _____

Yes No **Family History:**

Does any 1st degree relative (parents, siblings, children) have skin cancer? If so, please explain:

Does any 1st degree relative have allergies, hay fever, asthma, eczema? Explain:

Does any family member have any other skin diseases? Explain:

Patient Signature: _____

Date: _____

Medical History Form Reviewed by: _____

Date: _____

GI

Heartburn

Ulcers

Liver disease / Hepatitis

Gallstones

Irritable bowel

Other: _____

GU

Incontinence

Frequent urination

Kidney Stones

Dialysis

Other: _____

Age at menopause: _____

MUSCULOSKELETAL

Chronic back pain

Osteoarthritis

Rheumatoid arthritis

Lupus

Calf pain

Other: _____

NEUROLOGIC

Seizures/Epilepsy

Stroke

Headaches/Migraines

Alzheimer's disease

Other: _____

HEMATOLOGIC

Ankle/foot swelling

Varicose veins

Blood clots

Frequent/excessive bleeding

Other: _____

ENDOCRINE

Diabetes mellitus

Thyroid disease

Other: _____

PSYCHIATRIC

Stress/anxiety

Depression

Thoughts of suicide

Other: _____

MALIGNANCY

Cancer:

Treatment: _____

INFECTIONS

Fever blisters/cold sores

Herpes, location

Shingles

Chickenpox

Hepatitis (B or C)

Tuberculosis / +PPD

HIV

Other: _____

Surgeries: (including cosmetic procedures) _____ Date _____