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
5525 ETIWANDA AVENUE, SUITE 308, TARZANA, CA 91386 (818) 705-2901
40731 BIG BEAR BLVD. - BIG BEAR LAKE, CA 92315 (909) 866 – 8688
16899 ALGONQUIN STREET, SUITE A HUNTINGTON BEACH, CA 92649 (714) 840-2447
1045 ATLANTIC AVENUE, SUITE 519, LONG BEACH, CA 90813 (562)436-6787

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: ❑ 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 (circle one)

---------- REFERRAL INFORMATION ----------

How did you hear about our office? **Please check one**: **Beach Reporter ❑ Gazette Newspapers ❑ Online Ads ❑ Easy Reader ❑ South Bay Magazine ❑ Insurance book ❑ Google ❑ Bing ❑ 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 $30 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 (4) 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 WARTSO MOLLUSCUM
- ❑ SCARS EASILYO 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. ❑

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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

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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 ❑

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/Tarzana Dermatology/Long Beach Dermatology/Beach Cities Dermatology Medical Associates (Seal Beach office), 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/Tarzana Dermatology/Long Beach Dermatology/Beach Cities Dermatology Medical Associates (Seal Beach office) 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/Tarzana Dermatology/Long Beach Dermatology/Beach Cities Dermatology Medical Associates (Seal Beach office), for any services furnished to me by William J. Wickwire, M.D., Neal M. Ammar, M.D., Fariba Seraj, RNP/PA-C, Edward M Prodanovic, M.D., Geover Fernandez, M.D., and Steven Gammer, 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 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/Tarzana Dermatology/Long Beach Dermatology/Beach Cities Dermatology Medical Associates (Seal Beach office), for any services furnished to me by William J. Wickwire, M.D., Neal M. Ammar, M.D., Fariba Seraj, RNP/PA-C, Edward M Prodanovic, M.D., Geover Fernandez, M.D., and Steven Gammer, 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:_____