High Desert Skin and Laser Medical Center
Patient Registration Form

Thank you for choosing our office!
In order to serve you properly, we need the following PRINTED information.
All information will be confidential.

PATIENT ____ ☐ Male ☐ Female
Last First MI

Date of Birth ______ /______ /______ **Age** ______

Social Security # ___________________________ **Driver License #** _____________

Home Address (No P.O. Boxes Please) ____

City______________________________________ **State** _________ **ZIP** ___________

Home Phone (   ) ________ - ___________ **Cell** (   ) ________ - ____________

***Mailing Address (If different from above)______________________________________

City_______________________________________ State _________ ZIP ___________

Email Address ____

How did you hear about us? ____

Employer__________________________ **Occupation** ___________________________

Business Address____

Business Phone (   ) ________ - _____________

Responsible Party _________________________ Date of Birth _____ /_____ /__________

Social Security # _____________________ Employed by __________________________

Business Phone (   ) _____ - ________Occupation___________________________

PRIMARY INSURANCE *Please check this box if you have no insurance ☐

Insurance Carrier __________________________ Phone (   ) _______ - ___________

Address____

Insurance ID _____________________________ Group/Plan _______________________

Name of Insured _____________________________

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child

Amount of Your Co-Pay $____

SECONDARY INSURANCE

Insurance Carrier __________________________ Phone (   ) _______ - ___________

Address____

Insurance ID _____________________________ Group/Plan _______________________

Name of Insured _____________________________

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child

Amount of Your Co-Pay $____

Referred by: ____

EMERGENCY CONTACT (Name of relative or friend, not living with you)

Name___________________ **Relationship**__________ **Phone** (   ) _____ - __________

Insurance Deductible and Co-pay Responsibility

Your appointment today, as well as your future appointments, may incur charges for office visits and/or medical/surgical services. Your insurance may have deductible and co-pay amounts that will be collected on the date the service is provided. We make every effort to insure that the information we have regarding your insurance is accurate and up-to-date. If you are a self-pay patient with no insurance coverage, you are obligated to pay for the services at the time they are rendered. If you have any questions in regards to the office visit and/or medical/surgical services to be performed and/or their related charges, do not hesitate to inquire about these prior to the treatment. By signing below, you acknowledge that you understand what is requested of you in regards to today's visit and future visits, and that deductible and/or co-pay amounts are your responsibility to pay. If you are unable to meet this responsibility on the date the service is provided, please inform our front office staff to make other arrangements.

Photo, Video, Medical Records Authorization

I hereby consent to be interviewed, recorded, photographed, videotaped or filmed by the staff of Steven E Hodgkin, MD and the High Desert Skin and Laser Medical Center, and for purposes of publication, display or broadcast (print, web, digital display and all other forms of media). I agree that such interviews, recordings, articles, quotes, photographs, films, audio or video and/or any reproductions of same in any form, are the property of Steven E Hodgkin, MD and the High Desert Skin and Laser Medical Center, and I relinquish any present or future claim for reimbursement for said photographic or film reproduction of my likeness or for said testimonials by me. I hereby release Steven E Hodgkin, MD and the High Desert Skin and Laser Medical Center, its affiliates, employees, representatives and agents from any and all claims, demands, costs and liability that may arise from the use of these interviews, recordings, photographs, videotapes or films, and/or any reproductions of same in any form, as described above, arising out of being interviewed, recorded, photographed, videotaped or filmed.

I authorize Steven E Hodgkin, MD and the High Desert Skin and Laser Medical Center to release/obtain any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I understand that my medical records will be maintained for 7 years, but may be destroyed after 7 years.

I, ____ authorize Dr. Steven E. Hodgkin, MD and the High Desert Skin and Laser Medical Center to examine and provide medical treatment. I assume full responsibility for paying my insurance co-pay and/or deductible on the day the service is provided. I understand that I will receive a statement regarding any outstanding balance due after my insurance has paid their full amount. I understand timely remittance is expected and my account will be subject to collections if I fail to pay in full after 90 days. I authorize my insurance company to pay by check made out directly to Steven E. Hodgkin, MD or High Desert Skin and Laser Medical Center. I understand it is my responsibility to know all rules and restrictions of my insurance policy, to know which hospital, emergency rooms, laboratories, x-ray departments and specialists and specialist providers which are assigned to me according to my insurance policy rule. It is Steven E Hodgkin, MD and the High Desert Skin and Laser Medical Center's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals.

____ ________________________________

Patient or Responsible Party Signature Date

Facility Name: High Desert Skin Center	*Acknowledgement of Notice of Privacy Practices Form*	Revision Number: July 01, 2024

I have been given a copy of this Office's *Notice of Privacy Practices ("Notice")*, which describes how my health information is used and shared. I understand that this Office has the right to change this *Notice* at any time.

I am aware that I may obtain a current copy by contacting the Office's HIPAA Compliance Officer.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

Signature of Patient or Personal Representative	
Patient Name	
Name of Personal Representative (if applicable)	
Date	

In regards to your health information, you have both the right and choice as to who we can share your information with. Please list the following family, friends, or others involved in your care with which we can share your health information:

______________________________________ ______________________________________

For Facility Use Only: ***Complete this section if you are unable to obtain a signature.***

1. If the resident or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

   ____

   ____

2. Describe the steps taken to obtain the resident's (or personal representative's) signature on the *Acknowledgement:*

   ____

   ____

Completed by	
Signature of Facility Representative	
Date	

high desert | skin & laser medIcal center

Steven E Hodgkin, M.D.

Patient Name: ____ **Date:** __________________

Do we have permission to:

Leave a message on your answering machine? Y N

Leave a message at your place of employment? Y N

Discuss your medical condition with any member of your household? Y N

If yes, then whom? ____

Relationship: ____

I am at the office today: ☐ By myself

☐ With: Friend | Spouse | Relative

Name/Relationship:____

Patient or Responsible Party signature: ____ Date: _________________

Reason(s) for visit: (include location, duration, symptoms, and treatment)

1. ____
2. ____
3. ____
4. ____
5. ____

Skin Type: If exposed to the sun in the summer without sunscreen, you would:

☐ Always burn, never tan ☐ Always burn, sometimes tan ☐ Sometimes burn, tan gradually

☐ Burn minimally, tan well ☐ Rarely burn, tan profusely ☐ Never burn, deeply pigmented

High Desert Skin and Laser Medical Center is dedicated to educating you on your diagnosis, recommended labs/biopsies, and treatment options (potential risks and benefits), as well as treatment options available for all of your cosmetic concerns.

Please check the areas in which you would like information:

☐ Lines and wrinkles ☐ Acne scars

☐ Botox/Fillers ☐ Body contouring or fat reduction

☐ Sagging eyelids ☐ Facial veins/redness

☐ Dark circles under eyes ☐ Spider veins

☐ Brown spots ☐ Laser hair removal

☐ Neck rejuvenation ☐ Hair loss

PATIENT HISTORY

Date of Birth:	Sex: M / F	Height:	Weight:

GENERAL MEDICAL HISTORY – Please circle and date if you have or had any of the following:

Smoking - Cigs per day:	Arthritis - Rh / Osteo	HIV/AIDS
Alcohol - Drinks per day:	Artificial Joints	Radiation Treatment
Anxiety	Diabetes - Type I / Type II	Colon Cancer
Depression / Bipolar / Schizophrenia	Hepatitis - A / B / C / Medication	Seizures
Dementia / Alzheimer's	Pacemaker	Stroke
Migraines	Implantable Cardioverter Defibrillator	Hypothyroidism
Hearing Loss	Tuberculosis	Hyperthyroidism
Lung Cancer	Hypertension	Atrial Fibrillation
COPD	BPH (Benign Prostatic Hyperplasia)	Coronary Artery Disease
Asthma	Prostate Cancer	Herpes Simplex
Lupus	Brest Cancer	Shingles / Zoster
Kidney Disease / Dialysis	GERD	High Cholesterol / Triglycerides
Adrenal Disease	Lymphoma / Leukemia	Nonprescription medication?

Other:

SURGICAL HISTORY – Please circle and date if you have or had any of the following:

Biological Heart Valve	Breast Biopsy - Right / Left / Both	Colectomy - Colon Cancer / IBD
Mechanical Heart Valve	Lumpectomy	Kidney Biopsy / Surgery
Coronary Artery Stent	Mastectomy - Right / Left / Both	Kidney Removal
Coronary Artery Bypass	Breast Implants	Kidney Stone Removal
Prostate Biopsy	Breast Reduction - Right / Left / Both	Kidney Transplant
TURP	Cosmetic Surgery	Gallbladder Removal
Melanoma Surgery	Liposuction	Spleen Removal
Joint Replacement - Knee / Hip	Laser Surgery	Bone Marrow - Biopsy / Treatment

Other:

SKIN HISTORY – Please circle and date if you have or had any of the following:

Acne	Melanoma	Actinic Keratosis
Accutane	Skin Cancer	Psoriasis / Arthritis
Dry Skin	Skin Biopsy / Surgery	Flaking or Itchy Scalp
Eczema	Fungus - Foot / Groin / Nails	Fever Blisters

Other:

Do you wear sunscreen?	Y / N	What SPF?

OB/GYN HISTORY – Please circle and date if you have or had any of the following:

Ovarian - Cyst / Removal	Yeast Infection	Tubal Ligation (Tubes Tied)
Hysterectomy - Cancer / Fibroids	Pregnancies	Endometriosis
Genital Warts	Cervical - Dysplasia / Cancer	Vaginal Bleeding
Mammogram - Normal / Abnormal	Pap Smear - Normal / Abnormal	STD - Type?

Other:

Are you currently menstruating/postmenopausal?	Y / N	Date of last menstrual period:
How often do you have your period?		Monthly / Other: Period Duration: Days
How would you characterize your periods?		Light / Medium / Heavy
Are you contemplating pregnancy?	Y / N	When are you planning to be pregnant?
Are you currently pregnant?	Y / N	What is your due date?
Are you breastfeeding?	Y / N	When are you planning to stop?
Birth Control? Never / Currently / In the past		What type?
Have you had vaginal yeast infection(s)?	Y / N	
When taking antibiotics?	Y / N	Other cause(s)?

FAMILY HISTORY – Please circle any conditions affecting a ***BLOOD RELATIVE***:

Melanoma Cancer	Psoriasis	Asthma
Basal Cell Carcinoma	Eczema	Allergies
Squamous Cell Carcinoma	Acne	Hay Fever

Please specify relative / relationship: ____

List any other Family History Medical conditions not referenced above:

____

____

ALLERGIES – Please list all allergies and what type of reactions occur (i.e. rash, swelling, itching, blisters) below:

□ No known drug allergies or medication sensitivities

Allergen	Reaction