

Edward Becker M.D. Marvin Engle M.D. Norman Price M.D.
Melissa Pattee MPAS, PA-C Carey Cano, MHS, PA-C
2255 Ygnacio Valley Rd Suite B-1
Walnut Creek, CA 94598
Phone 925-945-7005 Fax 925-945-7084
www.edwardbeckermd.com

Dear Patient,

We look forward to seeing you at your upcoming appointment:

To expedite the process of the registration, please complete the attached registration forms.

1. Please complete all the forms in BLACK ink and bring them with you to your appointment.
2. You also may pre-register by sending in your packet via US mail or by fax prior to your appointment.
3. If you do not pre-register please arrive at least 20 minutes prior to allow us adequate time to process your paperwork.
4. For directions please visit our website www.edbeckermd.com
5. Please enter the building through the "West Door", our office is just few doors from the entrance on your left hand side.
6. Remember if you are unable to keep your appointment, please call us one business day ahead of time so another patient may utilize your appointment. Our practice charges a minimum of \$25.00 (depending of the length of the appointment) for appointments that are not canceled in the 24 hour requirement.

If you have any questions or concerns please feel free to call our office at the number above and we will be happy to assist you.

Sincerely,
Medical Staff
Edward Becker M.D. Dermatology

Enclosure;

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Name: _____ DOB: _____

Chief Complaint (summarize): _____

Past Medical History:

(Please place a mark on "Yes" or "No" to indicate if you have had any of the following):

Trouble Breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Develops Keloids/Hypertrophic Scars	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeds Excessively	<input type="checkbox"/> Yes <input type="checkbox"/> No	Takes Aspirin/Anticoagulants	<input type="checkbox"/> Yes <input type="checkbox"/> No
Contact Derm to Tape	<input type="checkbox"/> Yes <input type="checkbox"/> No	Contact Derm to Antibiotic Ointment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent Skin Rashes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Bacterial Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joints Implants	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is Immunosuppressed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	NONE	<input type="checkbox"/>

Difficulty with Oral Antibiotics: Nausea Headaches Yeast NONE

Patient Skin History: NONE

Skin Cancer:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Atopy (Hayfever, Asthma, Eczema)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psoriasis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Acne:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No _____		

Family Skin History NONE

Skin Cancer:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Atopy (Hayfever, Asthma, Eczema)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psoriasis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Acne:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No _____		

Surgical History:

_____	Date	____/____/____
_____	Date	____/____/____
_____	Date	____/____/____

Pharmacy Name: _____ Location: _____

Current Medications:	Strength	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: _____ Reaction: _____ [] No Known Drug Allergies (or list below)

Height: _____ Weight: _____ Pain Level (1-10) _____ Pregnant: Yes No N/A

Smoking Status: every day some days former smoker never

Alcohol: Yes No Describe Use: _____

CONSENT: I certify that the above information is true and correct to the best of my knowledge. I hereby authorize Edward Becker M.D. Dermatology to administer and perform such procedures that may be deemed necessary in the diagnosis and treatment.

Patient/Guardian Signature: _____ Date: _____

Initial _____

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PERSONAL INFORMATION

Acct _____

Patient Name _____
Last _____ First _____ MI _____
Address _____ City, State Zip _____
Home _____ Cell _____ Cell Carrier _____
Email: _____

Emergency Contact: Name _____ Phone _____
Is it ok to release information to this person regarding your care? YES NO

Sex _____ DOB _____ Age _____ Marital Status _____
SSN _____ License _____

EMPLOYMENT INFORMATION (Fill out for parent or guardian if patient is a minor)

DISABLED UNEMPLOYED RETIRED
Occupation _____ Employer Name _____
Address _____ City, St Zip _____
Phone _____

PRIMARY CARE PROVIDER INFORMATION

Primary Care Provider _____ Phone _____
Referring Provider _____ Phone _____

The following information is a requirement by the federal government please visit www.cms.gov
LANGUAGE English French Chinese Spanish Japanese Farsi Italian
RACE: _____ ETHNICITY _____

INSURANCE PLEASE COMPLETE THIS SECTION IN ITS ENTIRETY

Primary

Insurance Name _____ Policy/Subscriber# _____
Group # _____ Relationship to Self Spouse Child
Subscriber (please circle) Subscriber DOB _____

Secondary

Insurance Name _____ Policy/Subscriber# _____
Group # _____ Relationship to Self Spouse Child
Subscriber (please circle) Subscriber DOB _____

Initial _____

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Consent

I authorize the providers of Edward Becker M.D. Dermatology to retain all of my medical records / information in an electronic format. These records will be maintained in a secured, confidential manner and shall be in compliance with HIPAA Regulations for patient confidentiality. These records shall not be released without consent of the patient or legal guardian. This authorization remains in effect until revoked in writing. I understand that I have been provided a copy of the Notice of Privacy Practices and that a full version is available and also posted in this office.

Signature: _____ Date: _____

Insurance Authorization and Assignment

I hereby authorize Edward Becker M.D. Dermatology to furnish information to the insurance carrier (s) regarding my treatments. This authorization remains in effect until revoked in writing.

Signature: _____ Date: _____

Payment Obligations (see attached Practice Financial Policy)

I hereby assign, Edward Becker M.D. Dermatology all payments for medical services rendered to myself or my dependents until revoked in writing. I understand that I am responsible for any amount not covered by my insurance at the time of service to include co-pays, deductibles and non-covered services. I also understand that if I do not fulfill my payment obligations to Edward Becker M.D. Dermatology, my account will be subject to a full collections process. Any expenses related to the cost of collections and/or legal proceedings will be my responsibility. I acknowledge I have read a copy of the Practice's Financial Policy and that a copy will be made available for me to keep upon my request or I may retrieve it from www.edwardbeckermd.com.

Signature: _____ Date: _____

Medicare Patients Only

All Medicare patients must sign a lifetime beneficiary claim authorization. I request that payment of authorized Medicare benefits be made on my behalf to Edward Becker M.D. Dermatology for any services furnished by my doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of the medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the electronically submitted claims, physicians or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and deductibles are based upon the charge determination of the Medicare carrier.

Signature: _____ Date: _____

**NOTICE: Medical Doctors are licensed and regulated by the Medical Board of California,
1-800-633-2322 www.mbc.ca.gov.**