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PATIENT INFORMATION SHEET

Patient Last Name: _____ First Name: _____ Date of Visit: _____

Age: _____ Date of Birth: _____

Who can we thank for referring you?: _____

MEDICATION LIST:

ORAL Medications you take now and *Reason for taking*

1. _____

2. _____

3. _____

Additional medications: _____

TOPICAL medications: _____

Are you on birth control medication? Yes No

Do you take prophylactic antibiotics before surgery? Yes No

Do you take aspirin or ibuprofen? Yes No

Are you on coumadin? Yes No

ALLERGIES to any medications? Yes No **If Yes, to what?** _____

Do you have allergies to tape or latex? Yes No

MEDICAL HISTORY

Do you have any of the following conditions (check all that apply) or I don't have any medical problems

- | | | | | |
|------------------------------------|---|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Cholesterol (high) | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gastric reflux |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Keloids | <input type="checkbox"/> Lupus | <input type="checkbox"/> Radiation therapy |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Transplant |

OTHER: _____

SURGERIES? Bypass Hernia Hysterectomy C-Sections Tonsillectomy Appendectomy Gallbladder

OTHER: What/When: _____

Have you ever had a SKIN CANCER? Yes No

If yes? Was it a Basal cell Squamous cell Melanoma Don't know

** Please give location and approximate dates:

FAMILY HISTORY Melanoma Basal cell skin cancer Squamous cell skin cancer If yes, who? _____

Other skin illnesses: Eczema Psoriasis Lupus or problems that run in family?

There's more—please turn over. Thanks!

REVIEW OF SYSTEMS: Please check all of the conditions you currently have or check () NONE

Constitutional :	<input type="checkbox"/> Fever <input type="checkbox"/> Unexplained weight loss
Gastrointestinal:	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Eating problems
Genitourinary:	<input type="checkbox"/> Frequency <input type="checkbox"/> Burning <input type="checkbox"/> Difficulty <input type="checkbox"/> Irregular menstrual periods
Endocrine:	<input type="checkbox"/> Excess thirst <input type="checkbox"/> Hormone problems
Lungs/Respiratory:	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Problems breathing
Cardiovascular:	<input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Ankle swelling
Ear/Nose/Throat	<input type="checkbox"/> Hearing aid <input type="checkbox"/> Hearing problem <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Ear infections <input type="checkbox"/> Problems swallowing
Pregnancy issues:	<input type="checkbox"/> Currently pregnant <input type="checkbox"/> Planning pregnancy <input type="checkbox"/> Currently breast feeding
Lymph/Hematology	<input type="checkbox"/> Abnormal bleeding <input type="checkbox"/> Swelling of glands <input type="checkbox"/> Clotting problems
Eyes:	<input type="checkbox"/> Contact lenses <input type="checkbox"/> Blurred vision <input type="checkbox"/> Vision problem
Musculoskeletal	<input type="checkbox"/> Joint pain <input type="checkbox"/> Back pain
Allergy/Immunology	<input type="checkbox"/> Seasonal allergies/Hayfever
Neurological	<input type="checkbox"/> Migraines <input type="checkbox"/> Numbness <input type="checkbox"/> Seizures
Psychiatric:	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety

Who is your primary care Dr.? _____ Are they aware of these problems? Y No

SUNEXPOSURE HISTORY:

How much sun exposure have you had during your lifetime? Minimal Moderate Significant

Check off which type of skin best describes you? (please try to pick the one that best describes you)

SKIN TYPE	HAIR COLOR	EYE COLOR	SKIN COLOR	SUNSENSITIVITY	PIGMENTARY RESPONSE
<input type="checkbox"/> I	Red	Blue	Fair	Very high	Always burn
<input type="checkbox"/> II	Blond	Blue/green	Fair	Very high	Usually burn
<input type="checkbox"/> III	Brown	Green/brown	Medium	High	Sometimes burn
<input type="checkbox"/> IV	Brown	Brown	Tan	Moderate	Rarely burn
<input type="checkbox"/> V	Brown/black	Brown	Tan	Minimal	Very rarely burn
<input type="checkbox"/> VI	Black	Brown	Black	None	Never burn

What outdoor/sunexposure activities do you or have you done? golf tennis farmer boater gardener tanning booth
 life guarding outdoor occupation

Have you had several sunburns? Y N Were they blistering? Y N

Do you use sunscreen? Rarely Occasionally Always----- What kind? _____

Where do you usually use it? Face Arms Full body

SOCIAL HISTORY

Do you smoke? Yes No If yes, how much per day? _____ For how many years? _____

How much alcohol do you drink per week? None Rarely less than 14 drinks/week more than 14 drinks per week

Your occupation: _____ Retired
 Spouse's occupation (if applicable) _____ Retired

Marital status Married Not married Divorced Widowed
 Do you have any children? No Yes

Patient Signature: _____ **Date:** _____

Thanks for filling this out! We know that the paperwork is a pain but we do appreciate it!

For Office Use Only Reviewed by: _____ Date: _____

Unchanged other than what is reflected in Derm notes _____

HIPAA NOTICE OF PRIVACY PRACTICES DRS. MARK & MONA MOFID, M.D.,APC & DEL MAR LASER

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bill, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcements: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purpose as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with request to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____

Signature: _____

Date: _____