COAST DERMATOLOGY MEDICAL ASSOCIATES

SkyPark Building 1
23550 Hawthorne Blvd., Suite 200
Torrance, CA 90505
(310) 373-2636
FAX (310) 373-2633
www.CoastDermatology.com

Dedicated to the
Highest quality of patient care

Infant, Children and Adult
Dermatology

Diseases and Surgery
of the Skin, Hair and Nails

Skin Cancer Detection and
Treatment

Patch Testing for Skin Allergies

Skin Rejuvenation
- Botox
- Restylane
- Juvederm
- Radiesse
- Chemical Peels
- Microdermabrasion
- Laser Treatments

Treatment of spider and
varicose veins

Lasers Therapy for:
- Acne Scars
- Age Spots
- Broken Blood Vessels
- Fine lines and wrinkles
- Hair
- Scars
- Tattoos

Lasers Available:
- Fraxel
- Xeo
- IPL
- Varilite
- $C0^2$
- Cool Touch
- Cool Glide
- MedLite C6

Dear Patient,

Thank you for scheduling an appointment with our office. Available on this site are the medical health history and insurance forms that need to be completed prior to your visit.

Our practice is devoted to providing you with the best dermatologic and cosmetic care possible. We provide comprehensive dermatologic care for geriatric, adult, adolescent, and children. Our philosophy is to promote healthy attractive skin through preventative care by using the latest technological advances in dermatology.

Dr. David Horowitz and Dr. Mark Horowitz are board certified dermatologists, as well as diplomats of The Academy of Dermatology.

Besides being active in clinical practice, both physicians are program directors of Western University / Pacific Hospital of Long Beach Dermatology Residency Program. They are also professors of Dermatology at Western University of Health Sciences. Both are published authors in medical journals as well as frequent speakers at medical society meetings.

We look forward to your visit with us. Please take time to review the helpful hints section below. Fill out the online forms and bring them to your next appointment. This can expedite your registration. Please feel free to call us at (310) 373-2636 for any questions.

Sincerely,

Dr. David Horowitz and Dr. Mark Horowitz

<u>Helpful hints for an easy transition to our office:</u>

- Bring your medical insurance card and a driver's license.
- Find out if you have a co-pay or deductible.
- Make sure we are a provider of your insurance and check to see if you need a referral.
- We do not accept Medi-Cal, HMO of any kind, Kaiser, Health Care Partners IPA, or Tri-care HMO.
- Fill out the forms provided on this site, and bring them with you to your next appointment.
- Any medical reports that you would like us to review that were performed at another office should be obtained prior to your appointment with us.
- Payment is required at the time of your visit for co-pays, deductibles, cosmetic procedures, and all cash visits.
- Dependents under the age of 18 years old should be accompanied by a legal guardian.

David C. Horowitz, D.O.
Board Certified
Diplomat of the American Board of Dermatology

Mark K. Horowitz D.O.
Board Certified
Dermatology and Cosmetic Surgery

Dr. Horowitz
SkyPark Building 1
23550 Hawthorne Blvd., Suite 200, Torrance CA 90505
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PATIENT REGISTRATION FORM
(PLEASE PRINT CLEARLY AND FILL OUT COMPLETELY)

Email Address:_____
(Special Offers and Newsletter will be sent periodically to all our Valued Patients)

Patient Name:_____ SSN:_____

Street:_____ Date Of Birth:_____ Age:_____Sex: M F

City:_____ State: _____ Zip:_____ Home Phone:_____

Billing Address If Different Than Above: Cell Phone:: _____

Street:_____

City:_____ _____State:_____ Zip:_____ Home Phone:_____

Marital Status: M S D W

Spouse: _____

Emergency Contact:_____ Phone Number:_____

Responsible Party:_____ SSN:_____

Street:_____ Date of Birth:_____ Age:_____

City:_____ State:_____ Zip:_____ Home Phone:_____

Employer:_____ Work Phone:_____

How Did You Hear About Us? ___ Yellow Pages ___ Web ___ Other _____

Family _____ Friend _____ Physician _____

PRIMARY INSURANCE:	SECONDARY INSURANCE:
NAME:_____	NAME:_____
ID no.:_____	ID no.:_____
Group no.:_____	Group no.:_____
Insured Name:_____	Insured Name:_____
Insured DOB:_____	Insured DOB:_____

ACKNOWLEDGEMENTS/DISCLOSURES

_____
PATIENT NAME

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Can confidential messages be left on your answering machine or voicemail?
   YES NO
2. Please list, if any, person(s) whom we may inform about your general medical condition, your diagnosis, and/or your payment options:

NAME: _____ Phone Number: _____

NAME: _____ Phone Number: _____

ASSIGNMENT OF BENEFITS:
I assign all insurance benefits to Dr. Horowitz. I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that Dr. Horowitz's office is not responsible to know my plan, what it will pay for or the deductible requirements. I hereby give my consent for examination, treatment and insurance billing.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE PRIVACY PRACTICES:
I hereby acknowledge that a copy of this medical practice's Notice of Privacy Practices is available and posted in the reception area and will be given a copy upon request.

Please be advised that we accept Medicare. We DO NOT ACCEPT MEDI-CAL.
I acknowledge that I am responsible for all charges not paid by insurance/Medicare.

COSMETIC VISITS: If you are here for cosmetic purposes and inquire about dermatology issues during treatment, your insurance **will be billed** accordingly. You are financially responsible for all charges whether or not paid by insurance.

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California, (800) 633-2322, www.mbc.ca.gov

Signature: _____ DATE: _____
Patient/Responsible Party

Print Name: _____

If not signed by the patient, please indicate:

Relationship: _____

Dermatology Medical History

Patient: _____ Date of Birth::____/____/____ Today's Date: ____/____/____

Reason for today's visit: _____

Are you allergic to any medications? ❑ YES ❑ NO If yes, list below:
1. _____ 2. _____

Have you ever had dental anesthesia (Novocaine)? ❑ YES ❑ NO Any bad reaction? ❑ YES ❑ NO

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):
1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	**YES**	**NO**
Bronchitis	❑	❑
Emphysema	❑	❑
Asthma	❑	❑
Chronic Cough	❑	❑
Morning Cough	❑	❑
Shortness of Breath	❑	❑
Wheezing	❑	❑

Cardiovascular:	**YES**	**NO**
High Blood Pressure	❑	❑
Chest Pain	❑	❑
Heart Attack	❑	❑
Heart Murmur	❑	❑
Irregular Heartbeat	❑	❑
Phlebitis	❑	❑
Inflammation of vein	❑	❑
Blood clots	❑	❑
Pacemaker	❑	❑

Other Systemic:	**YES**	**NO**
Diabetes	❑	❑
Excessive thirst/hunger	❑	❑
Amputation	❑	❑
Thyroid	❑	❑
Kidney	❑	❑
Dialysis	❑	❑
Bladder	❑	❑
Frequency/burning	❑	❑
Gastrointestinal		
Stomach absorptive disorder	❑	❑
Nausea, vomiting, diarrhea when taking antibiotics	❑	❑
Yeast infection when taking antibiotics	❑	❑
Arthritis/Joint Deformity	❑	❑
Arthralgia	❑	❑
Limited motion	❑	❑
Artificial joint	❑	❑
Convulsions, Epilepsy or Seizures	❑	❑
Fainting	❑	❑

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin:
Have you ever had skin cancer? ❑ YES ❑ NO
Has anyone in your family had skin cancer? ❑ YES ❑ NO
Do you have a history of any specific skin diseases? ❑ YES ❑ NO If yes, _____
Do you have problems with healing ❑ YES ❑ NO
Do you develop keloids (scars) after surgery ❑ YES ❑ NO
Do you bleed easily? ❑ YES ❑ NO
Do you develop skin rashes in reaction to ❑ Medications ❑ Food ❑ Environment ❑ Bandages ❑ Topical Neosporin ❑ Other _____

Social History:
Do you drink alcohol? ❑ YES ❑ NO If YES _____ drinks per day
Do you use IV drugs? ❑ YES ❑ NO If YES, what? _____ How often? _____
Do you smoke? ❑ YES ❑ NO If YES, how much: _____
Have you had or have you been exposed to HIV (AIDS) ? ❑ YES ❑ NO

Please answer the following questions:
(Women) Are you pregnant? ❑ YES ❑ NO Due Date: ___/___/___
What is your occupation? _____ Hobbies? _____

Completed by: ❑ Patient ❑ Medical Assistant _____ Initials

_____ ___/___/___
Signed by Patient Date

_____ ___/___/___
Reviewed by Date