Longevity Physician Specialists: Dermatology Division

PATIENT INFORMATION

Patient's Last Name: First: Middle:			Gender: ❑ Male ❑ Female	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Date of Birth: / /	Age:	Social Security #
Preferred Language:	Ethnicity: Please Circle Hispanic \ Non-Hispanic		Race:	
Street address:	City:	State:	Zip Code:	

Please check best contact phone number below:

❑ Home Phone: ( )	❑ Work Phone: ( )	❑ Cell Phone: ( )
Please list any patients of Dermatology Specialists that you are related to:		
Patients employment status: Active \ Retired \ Student \ N\A	Employer:	Employer Phone:
Occupation:		
Chose clinic because/Referred to clinic by (please check one box):	❑Family ❑ Friend ❑Internet ❑Ad ❑Physician ❑ Insurance Plan Name:_____	
Referring Doctor:	Physician's Number: ( )	
Primary Care Physician:	Physician's Number: ( )	
Name of Emergency Contact:	Relation to Patient:	Home Phone: ( ) Cell Phone: ( )

INSURANCE INFORMATION

Policy Holder's Name:		Date of Birth: / /	Social Security #:	
Insurance name:	❑ Check if address of policy holder is the same as above. If not, please provide the complete address below:			
Patient's relationship to policy holder:	❑ Self	❑ Spouse	❑ Child	❑ Other
Policy holder's employment status: Active \ Retired \ Student	Employer:		Employer Phone: ( )	
Secondary Policy/Policy Holder's Name:		Date of Birth: / /	Social Security #:	
Insurance name:	❑ Check if address of policy holder is the same as above. If not, please provide the complete address below:			
Patient's relationship to policy holder:	❑ Self	❑ Spouse	❑ Child	❑ Other
Policy holder's employment status: Active \ Retired \ Student	Employer:		Employer Phone: ( )	

This practice requires your email address to gain access to your Personal Medical Records via our secure Patient Portal.

Email Address: _____

You will receive electronic communication (unless we are otherwise notified) regarding scheduled appointments, lab work results, request prescription refills, request appointments, contact our medical staff, and you will also be able to update your information.

Our office participates in electronic submission of lab work, pathology and prescriptions. This system allows us to submit prescription during your visit in our office. Please list the pharmacy below where we can send your prescription.

Pharmacy Name: _____ Location: _____

Patient/Parent Signature: _____ Date: _____

See back side of Form

Allergy and Dermatology Specialists

LONGEVITY PHYSICIAN SPECIALISTS

Dermatology Division

Lucy Li, MD ●Nancy Chung, MD
Bradley Armstrong, PA-C ●Katie Vo, PA-C ● Mary Gurney, PA-C

Office Policies:

Attention Patients:

Please be advised that here at Longevity Physician Specialist, we will make every effort to contact your insurance company to verify your insurance benefits. However, the insurance companies will only provide a quote of benefits and not a guarantee of payment. Because we collect the amount due at the time of service, according to the quote given, there may be a difference in patient responsibility once we file your claim.

Financial Responsibility
I am aware that co-pays, deductibles, co-insurance, and payment of cosmetic procedures that are not covered by my insurance are my responsibility and are due at the time of service. I understand that LPS will attempt to verify my coverage, but if my insurance fails to reimburse despite the efforts, I will be responsible for paying the bills in full. I understand that I am responsible for knowing what my insurance benefits are and for obtaining a referral if it is required by my insurance policy. I will inform any changes in my insurance plan immediately. Any charges that result from failure to do so will be solely my responsibility. I authorize payment of medical benefits to the provider of service.

Initial_____

Cancelation Policy
LPS reserves the right to charge patients who fail to cancel their medical appointments within 24 hour notice (business days), cosmetic and surgical and Saturday appointments within 48 hour notice (business days). Our office provides a courtesy reminder call, however it should not be relied upon for a confirmation of an appointment. We will make every effort to accommodate your requests for an appointment, and ask you in return to be courteous and punctual.

Initial_____

Authorization for Medical Treatment of a Minor
I, being the parent or guardian of the above named minor, do hereby authorize providers of the LPS to administer dermatologic medical treatment to my child. It is my intention that this authorization be effective during my absence.

Initial_____

Female Patients of Child Bearing Potential
I understand that if I am trying to get pregnant or I become pregnant I will stop all oral and topical medications you have prescribed and contact this office.

Initial_____

Responsible Party for Minors: (Please list the Parent that accompanied child today.)

Please be aware, if the responsible party was designated by a court order and is not present today, it is our office policy to request a copy of the court order from you.

Name: _____ Date of Birth _____

Address: _____

Relationship to Patient: _____ Are you a patient of our office? ❑ Yes ❑ No