CONTOUR DERMATOLOGY
& COSMETIC SURGERY CENTER

TIMOTHY M. JOCHEN, MD
BOARD CERTIFIED DERMATOLOGIST

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Title: ( ) Dr. ( ) Mr. ( ) Mrs. ( ) Ms. ( ) Miss.

Legal Name *(as it appears on insurance card):* _____
First *Middle* *Last*

Date of Birth: _____ / _____ / _____ Sex: ( ) Male ( ) Female SSN: _____-_____-_____

Race:_____ Ethnicity: _____ Preferred Language: _____

Religion:_____ Occupation: _____ Employer: _____

CONTACT INFORMATION

Mailing Address: _____
Street # *Street Name* *Apt/Unit#*

_____
City *State* *Zip code*

Home #: _____ Work #: _____ Mobile #: _____

What is your preferred method of contact? ( ) Home Phone ( ) Mobile Phone ( ) Text Message ( ) Email

May we email you appointment reminders, newsletters and specials, if so please provide your email:
Email Address: _____

Spouse Name: _____ Phone#:_____ Spouse's Date of Birth: ____/____/_____

Emergency Contact:_____ Phone#:_____ Relation:_____

PARENT OR RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

Name: _____ Date of Birth: ____/____/_____ Sex: ( ) M. ( ) F.
First Middle Last

Address: _____

Home #: _____ Work #: _____ Mobile#: _____

REFERRAL SOURCE

How did you hear about our practice? ( ) Physician: _____ ( ) Patient: _____

( ) Webpage: _____ ( ) Commercial ( ) Newspaper ( ) Billboard ( ) Other: _____

PATIENT PRIVACY

Do we have your permission to discuss your medical condition or allow any member of your household to schedule appointments for you?
If Yes, whom: _____ Relationship:_____

If your primary care provider is given we will be sending their office your progress notes unless asked not to:
Primary Care provider: _____

Do we have your permission to:
Leave a message on your answering machine at home? ( ) YES ( ) NO
Leave a message at your place of employment? ( ) YES ( ) NO

Contour Dermatology reminds patients of their appointments by text message, email and by phone call.
If at any time you would like to discontinue one of these communcations you may contact our office to cancel.

Patient Signature: _____ Date: _____

CONTOUR DERMATOLOGY
& COSMETIC SURGERY CENTER

TIMOTHY M. JOCHEN, MD
BOARD CERTIFIED DERMATOLOGIST

MEDICAL HISTORY FORM

LABS AND PATHOLOGY

If your insurance requires biopsies or cultures to be sent to specific lab (i.e. Tenet or EMC), please specify: _____
If not, all biopsies & cultures will be processed through our lab choice and *you will be responsible for all charged incurred with them*

ALLERGIES

Are you allergic to any medications? ☐ YES ☐ NO If yes, please list: _____

MEDICATIONS/PRODUCTS

Pharmacy of Choice: _____ Pharmacy Phone #:_____ Cross Streets: _____
Please list all medications you are currently taking (including prescriptions, over-the-counter meds, & vitamins):
Prescriptions: _____
Over-the-Counter: _____

PAST MEDICAL HISTORY

- Do you drink alcohol? ☐ YES ☐ NO If yes, how many per day? _____
- Do you smoke? ☐ YES ☐ NO ☐ FORMER SMOKER
- Have you ever had HIV (AIDS) or Hepatitis? ☐ YES ☐ NO
- Have you ever had skin cancer (Basal Cell Carcinoma, Squamous Cell Carcinoma, and/or Melanoma)? ☐ YES ☐ NO

If yes: Year diagnosed:_____ Location: _____ Type of Skin Cancer:_____
Year diagnosed:_____ Location: _____ Type of Skin Cancer:_____

- Has anyone in your family had a history of skin cancer? ☐ YES ☐ NO Type of Skin Cancer:_____
- List any other diseases or conditions: _____
- List any surgical procedures you have had in the past year:_____

Height:_____ Weight: _____

REVIEW OF SYSTEMS: Check off if you have a history of or currently have any of the listed diseases or conditions:

DERMATOLOGY	History of	Currently
oily skin	☐	☐
dry skin	☐	☐
red or brown spots	☐	☐
fine lines/wrinkles	☐	☐
sun damage	☐	☐

GENERAL	History of	Currently
currently pregnant		☐
currently breast feeding		☐
diabetes	☐	☐
reaction to antibiotics	☐	☐
reaction to bandages	☐	☐
anticoagulant daily	☐	☐

ENDOCRINE	History of	Currently
excessive sweating	☐	☐
heat/cold intolerance	☐	☐

MUSCULOSKELETAL	History of	Currently
arthritis/joint deformity	☐	☐
artificial joints	☐	☐

GASTROENTEROLOGY	History of	Currently
nausea	☐	☐
vomiting	☐	☐
GI problems	☐	☐

PSYCHOLOGY	History of	Currently
depression	☐	☐
suicidal thoughts	☐	☐
mental/physical abuse	☐	☐
mood swings	☐	☐
obsessive-compulsive	☐	☐

BLOOD/LYMPH	History of	Currently
swollen glands	☐	☐
fatigue	☐	☐
varicose veins	☐	☐
easy bruising	☐	☐
bleed easily	☐	☐
blood clots	☐	☐
thyroid problems	☐	☐

CARDIOLOGY	History of	Currently
chest pain	☐	☐
palpitations	☐	☐
leg swelling	☐	☐
heart attack	☐	☐
high blood pressure	☐	☐
pacemaker	☐	☐

NEUROLOGY	History of	Currently
headaches	☐	☐
tingling/numbness	☐	☐
seizures/dizziness	☐	☐

RESPIRATORY	History of	Currently
asthma	☐	☐
chest tightness	☐	☐
cough/wheezing	☐	☐
bronchitis	☐	☐
emphysema	☐	☐

- Do you have a history of any other specific skin diseases/reactions? ☐ YES ☐ NO
  If yes, please describe: _____

NOTICE TO CONSUMERS:
Medical doctors are licensed and regulated by the Medical Board of California (800) 633-2322

Patient Signature: _____ Date: _____

CONTOUR DERMATOLOGY
& COSMETIC SURGERY CENTER

TIMOTHY M. JOCHEN, MD
BOARD CERTIFIED DERMATOLOGIST

FINANCIAL POLICY

Welcome to Contour Dermatology and Cosmetic Surgery Center! We are pleased that you have chosen us as your health care provider. Our mission is to provide you with the highest level of professional medical care with the highest degree of patient satisfaction. To avoid any misunderstandings and ensure timely payment for services, it is important that you understand your financial responsibilities with respect to your health care.

INSURANCE Patients will be asked to present their insurance card upon check-in at the office each time they are seen for medical services. As a courtesy, we bill your primary and secondary insurance carriers. If your insurance company hasn't processed your claim within 45 days, the balance will transfer to you. We'll send you a statement, and you're welcome to contact your insurance company directly for reimbursement.

PATIENT RESPONSIBILITY Patients or their legal representatives are responsible for all charges for services provided, including copayments, co-insurance, deductibles, non-covered services, returned checks, and any collection fees. It is your responsibility to confirm our providers are in-network and obtain any required referrals or authorizations prior to your appointment. Payment is expected at the time of your visit for all charges owed for that day, as well as any previous balance. If a deposit is required, an estimate of your expected responsibility will be collected at the time of service. Please note that a $30 service fee will apply to any returned checks.

LABS AND PATHOLOGY If your insurance requires laboratory specimens to be sent to specific lab it is your responsibility as a subscriber to know the participating labs,

specify your preferred lab: _____

(If no lab noted we will send biopsy specimens and cultures to our normal lab and you will be responsible for all charged incurred with them). Urgent slide preparations are completed by Eisenhower Medical Center and you will be billed by them separately. As a courtesy we will forward your insurance information to these companies for billing purposes.

PAST DUE BALANCES AND COLLECTIONS If we don't receive payment from you or your insurance company within 90 days of your service date, your account may be referred to a collection agency. Once your account has been referred, you must work directly with the collection agency to make payment arrangements. We are unable to see you as a patient until your account has been resolved.

CANCELLATION AND NO-SHOW POLICY If you are unable to keep your appointment, please notify our office at least twenty-four (24) hours in advance to avoid a $75 no-show fee. This fee must be paid before scheduling another appointment. Patients with three or more no-shows within a six-month period may be dismissed from the practice.

REFUND POLICY Refunds cannot be requested after treatment have been performed. There is a 8% processing fee (based on refund amount) that is applied to all non-surgical and surgical procedure refunds requested and deducted from total refund amount.

SKIN CARE AND RETAIL PRODUCTS Resale skin care and retail product sales are final and non-refundable. For health and safety reasons, we cannot accept returns, credits, or exchanges on prescription or non-prescription products once they have been sold. This policy complies with California Civil Code §1723 and ensures that every product dispensed is safe, effective, and uncompromised.

CREDIT CARD ON FILE

At Contour Dermatology we require keeping your credit or debit card on file as a convenient method of payment. By providing your card, you're authorizing us to automatically charge your portion of the bill after insurance has been applied, including deductibles, copays, and outstanding balances. Your card is securely stored in compliance with PCI DSS and HIPAA standards.

Charges are capped at $400 per transaction, and any amount above that requires your verbal approval. This authorization stays in effect until you notify us otherwise in writing, and your account is in good standing.

As a patient of Contour Dermatology, your signature below signifies that you understand our Financial Policy.

Patient Signature: _____ Date: _____

CONTOUR DERMATOLOGY
& COSMETIC SURGERY CENTER

TIMOTHY M. JOCHEN, MD
BOARD CERTIFIED DERMATOLOGIST

NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by: _____
Printed Name – Patient or Representative

Relationship to Patient (if other than patient): _____

Patient Signature: _____ Date: _____

CONTOUR DERMATOLOGY
& COSMETIC SURGERY CENTER

TIMOTHY M. JOCHEN, MD
BOARD CERTIFIED DERMATOLOGIST

COSMETIC QUESTIONNAIRE

Dear Patient,

Our goal is to respond to all of our patient's needs and to provide the highest quality care. In order to provide the information on services and products you desire on the health and appearance of your skin, we invite you to complete the following questionnaire:

PLEASE CHECK ALL CONDITIONS/SYMPTOMS THAT APPLY:

( ) Brown spots on face
( ) Cellulite reduction
( ) Crease near nose/mouth
( ) Dimpled chin
( ) Excess skin above eyes
( ) Frown lines
( ) Gummy smile
( ) Lines around my eyes
( ) Lines between my eyes
( ) Lines on my forehead
( ) Lines under my eyes
( ) Looking tired
( ) Puffy eyes
( ) Red blotchy skin
( ) Sagging neckline
( ) Scarring
( ) Sunk in/hollow eyes
( ) Thin face, no cheeks
( ) Thin lips
( ) Unwanted veins
( ) Wrinkles

PLEASE CHECK ALL SERVICES/PRODUCTS THAT INTEREST YOU:

( ) Blepharoplasty
( ) Botox/Dysport
( ) Chemical Peels
( ) CoolSculpting
( ) Facial Fillers
( ) Facials
( ) Fat Transfer
( ) Hair Transplant Neograft
( ) Hair Transplant Strip Grafting
( ) IPL (Intense Pulse Light)
( ) Laser Hair Removal
( ) Laser Resurfacing
( ) Laser Treatments
( ) Lipodystrophy Treatments
( ) Liposuction
( ) Mini Facelift
( ) Neck/Jowl Tightening
( ) Non-Invasive Fat Reduction
( ) Picoway Laser Technology
( ) Profound
( ) Skin Care Products
( ) Tattoo Removal
( ) Ultherapy
( ) VelaShape III

PLEASE ANSWER THE FOLLOWING QUESTION ON A SCALE OF 1 TO 5 BY CIRCLING THE APPROPRIATE NUMBER:

When looking in the mirror, I believe I look younger, the same as, or older than my true age:

Younger Than		True Age		Older Than
1	2	3	4	5

What are you currently using as your skin care regimen (please list below):

( ) Cleanser/Toner: _____
( ) Sunscreen: _____
( ) Retin-A: _____
( ) Eye Cream: _____
( ) Moisturizer: _____
( ) Night Cream: _____

Patient Signature: _____ Date: _____