Camilla **McCalmont**, MD
Shan **Pai**, MD
Jennifer **Fu**, MD

A medical dermatology practice

Personal

Name: _____ Date of Birth: _____ Gender: ☐ M ☐ F

Telephone number(s): (H) _____ (C) _____ (W) _____

Email: _____

Address: _____

City: _____ ZIP: _____

Do we have permission to leave a message on your home or cell phone? ☐ Yes ☐ No

Emergency Contact: _____ Phone: _____

Primary Care Physician

Name: _____

Address: _____

Pharmacy

Name: _____

Address: _____

Medications

_____

_____

Allergies

☐ Latex ☐ Lidocaine ☐ Epinephrine ☐ Other _____

_____

Skin History

Skin Cancer? ☐ Yes ☐ No List Types(s) _____

Family History of Melanoma? ☐ Yes ☐ No Relationship: _____

Other Skin Problems _____

_____

6431 Fairmount Ave. | Suite 3 | El Cerrito, CA 94530 | camillamccalmont.com | 510.527.8865 | fax: 510.527.4123

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Medical History

_____

_____

Cardiac Condition? ☐ Yes ☐ No **Immunosuppressed?** ☐ Yes ☐ No **Diabetic?** ☐ Yes ☐ No

List Surgeries: _____

_____

Smoker? Yes ☐ No ☐ **Former Smoker?** Yes ☐ No ☐

Have you had any of the following conditions?

- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ BPH
- ☐ BreastCancer
- ☐ ColonCancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Seizures/stroke
- ☐ Other significant conditions: _____

Insurance Information

Name of Primary Inusurance: _____ Group Number: _____

Subscriber Name: _____ Member Number: _____

Name of Secondary Inusurance: _____ Group Number: _____

Subscriber Name: _____ Member Number: _____

I (the undersigned) accept responsibility for any fees not covered by my insurance.

_____

Signature Date

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Patient Financial Responsibility Agreement

As a patient, it is in your best interest to know and understand your insurance plan benefits and your responsibility for any deductibles, co-insurance, or co-payment amounts prior to any visit. Not all services are covered in all insurance contracts. In addition, you should be sure that your physician is listed as a participating provider by your insurance company. If your insurance plan does not cover a service or procedure, you are responsible for payment of these charges.

In the event that your insurance is not valid or your coverage was terminated at the time the services are rendered, you will be solely responsible for the full amount of your office visit and/or any procedures rendered.

In addition, if your insurance plan determines a service or procedure to be "not covered", you will be responsible for the complete charge of such services.

I agree to be responsible for the payment of all unpaid services rendered on my behalf or my dependents, including any fees for collection service needed.

I (the undersigned) accept responsibility for any fees not covered by my insurance.

_____ _____

Patient/Guardian Signature Date

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