DR | NIKKO
COSMETIC SURGERY
DERMATOLOGY
SKIN CARE

Patient Information Forms

Please legibly print the following information on the front and back in black ink

Patient Name: ____
Last First Middle

Home Address: ____
Street & Apt. City State Zip

Home Phone: ____________________ **Cell:** ______________________ **Work:** ____________________

Date of Birth: ________________ **Gender:** ________ **E-mail:** ________________________________

Marital Status: Single ______ **Married (Spouse's Name):** __________________________________

Emergency Contact: ________________________________ **Relationship:** ____________________
(Name)

Contact Phone: ____________________________ **Alternate Phone:** ____________________________

I will be using insurance for my dermatology appointment: ______NO ______YES

If yes,

Insurance Company: ______________________________ Relationship to Insured Party: _____________
Member ID: _______________________ Group #: _______________________
Insured Party Name: (First, Last) _____________________________ Insured Party DOB: ___/___/___

Referral Source (check all that apply):

______Social Media ______Website / Web Search ______Magazine ______Word of Mouth

______TV Commercial ______Yellow Pages ______Radio ______Other

Patient that we can thank for referring you (Name): ____

CANCELLATION AND NO SHOW POLICY

EFFECTIVE 09/27/2019

In order to provide the highest quality of care to our patients, we have established a formal, "Cancellation & No Show Policy." This is intended to increase physician and staff productivity, to improve timely access to all patients, and to reduce/eliminate empty slots in the appointment schedule.

To reserve an AESTHETIC PROCEDURE appointment we require a ***$50 reservation deposit,*** *in which, will go towards your service.*

We understand there may be circumstances that require you to cancel an appointment; however we require that you notify our office ***at least 48 hours*** in advance to avoid charges.

In the event you are unable to make it your appointment and either cancel or no show within the 48 hours, you will lose your reservation deposit and will be charged accordingly for future appointment.

____

Patient Name (print)   Patient Signature   Date

Nikko Dermatology & Cosmetic Surgery Center
Authorization for and Release of Photographs and Videos

I authorize Anthony Nikko, M.D. and his associates the right to use photographs and videos of myself for my professional medical purposes deemed appropriate, including, medical purposes related to the case, before and after photographs for patients to view in the office, Nikko Dermatology and Cosmetic Surgery Center website and all outlets of Social Media. I understand my name will be kept private and confidential, unless I authorize.

I understand Dr. Anthony Nikko M.D. is not obligated to make use of the rights to set forth herein. I also understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images.

___I DECLINE for all of my images to be posted/shared
___I AUTHORIZE for my images to be posted/shared
___I AUTHORIZE for my images to be posted/shared with the exception of my entire face

____

Patient Signature   Date

*(*If Patient is a minor, legal representative must sign consent)*

<u>Please check “Yes” or “No” for the following questions:</u>

Are you **ALLERGIC** to any medications? (List below) _______NO _______YES

____

____

Have you ever been diagnosed with **Hepatitis**? _______NO _______YES
If so, CIRCLE which: Hepatitis A B C

Do you have or have you been exposed to the **HIV virus**? _______NO _______YES

Do you have a problem with **excessive sweating**? _______NO _______YES

Please list the cosmetic procedures, skin care and/or dermatology treatments you are interested in:

____

____

First day of last period:____________________________**Number of Pregnancies:** ___________________

What pharmacy would you like to add for prescriptions?

Pharmacy Name: ____

Pharmacy Address:____

Phone Number: ____

I have received this office’s Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I fully understand that I am financially responsible for ALL medical services provided to me at the time of service.

____
Patient Signature **Date**
(*If Patient is a minor, legal representative must sign consent)

HIPPA Privacy Rule

In general, the HIPPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request that communications be made in a confidential manner.

I wish to be contacted in the following manner (check all that applies):

□ * HOME Telephone Number: ___________________________________

- □ O.K. to leave message with detailed information (e.g., appointment reminders)
- □ Leave message with call-back number ONLY

□ * CELLULAR Telephone Number:___________________________________

- □ O.K. to leave voice/text message with detailed information (e.g., appointment reminders)
- □ Leave voice/text message with call-back number ONLY

□ * WORK Telephone Number:___________________________________

- □ O.K. to leave message with detailed information (e.g., appointment reminders)
- □ Leave message with call-back number ONLY

*(Please check at least one) at the above number(s), you authorize our office to speak with:

- □ Emergency contact listed
- □ Patient only
- □ Patient and/or other authorized person(s)

Please list name(s) below:

____

____

____

____

Patient Signature **Date**

(*If Patient is a minor, legal representative must sign consent)

NAME:____ **DATE:**____/____/______

DATE OF BIRTH: ___/___/____ Name I prefer to be called: ____________________

PAST MEDICAL HISTORY (Please **circle** all that apply)

Anxiety	End Stage Renal Disease	Leukemia or Lymphoma
Depression	Hearing Loss	Radiation Treatment
Arthritis	Heart Attack/Stroke	Pacemaker
Artificial Joints	Hepatitis B or C	Cancer:__________________________
Diabetes	HIV/AIDS	Other:___________________________
None of the Above		

PAST SKIN DISEASE HISTORY (Please **circle** all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Melanoma	Vitiligo
Pancreatic Mole	Asthma	Hayfever/Allergies
Eczema	Flaking or Itchy Scalp	Psoriasis
Basal Cell Carcinoma	Squamous Cell Carcinoma	Melanoma
None of the Above	Other____	

PAST SURGICAL HISTORY (Please **circle** all that apply)

Heart Valve Replacement	Skin Biopsy	Melanoma Surgery
Squamous Cell Carcinoma Surgery	Basal Cell Carcinoma Surgery	Lumpectomy
Masectomy	Joint Replacement ______________	Cosmetic surgery
Other: _________________________	None of the above	

Do you wear Sunscreen? Yes No

If Yes, what SPF?_____________ how often? daily sometime only at the beach

FAMILY HISTORY (Please circle all that apply)

- □ Do you have an immediate family history of melanoma? **Yes** or **No**. If yes (Mother Father Sister Brother or Child)
- □ Are there any pertinent or major skin problems that run in your family? ____

SOCIAL HISTORY:

- □ Currently Smokes? Yes or No, if yes- how many____ Cigarette a day, for how many year? _________________
- □ Alcohol? Yes or No, if yes, how many drinks daily?____
- □ Are you on any kind of diet? Yes or No**,** If yes what diet? ____
- □ What is your current and/or former occupation? ____
- □ What type of outdoor activities, if any, do you participate in? ____
- □ Do you have any other hobbies or activities you would like us to know about? ____________________________
- □ Do you have any children or pets? ____
- □ With whom, if anyone, do you live? ____
- □ Where do you live (generally speaking: what town or city or county, assisted living facility)? ____________________ ____
- □ Are you currently using any dermatology lotion for skin care? Yes or No, if yes what product?___________________
- □ Are you interested in cosmetic surgery? Yes or No____

MEDICATIONS (Please List any medications, including vitamins and supplements, doses & frequencies, tablet or liquid)

Medications	Doses	Directions

ALLERGIES TOP MEDICATIONS (Please list any medication allergies and the **type of reaction** that occurred**)**

____

PHARMACY (Please provide the pharmacy name, phone#, and address)

____

PRIMARY CARE DOCTOR: ______________________REFERRING DOCTOR:___________________________

DERMATOLOGY ALERTS (Please **circle** any of these important alerts if they apply to you)

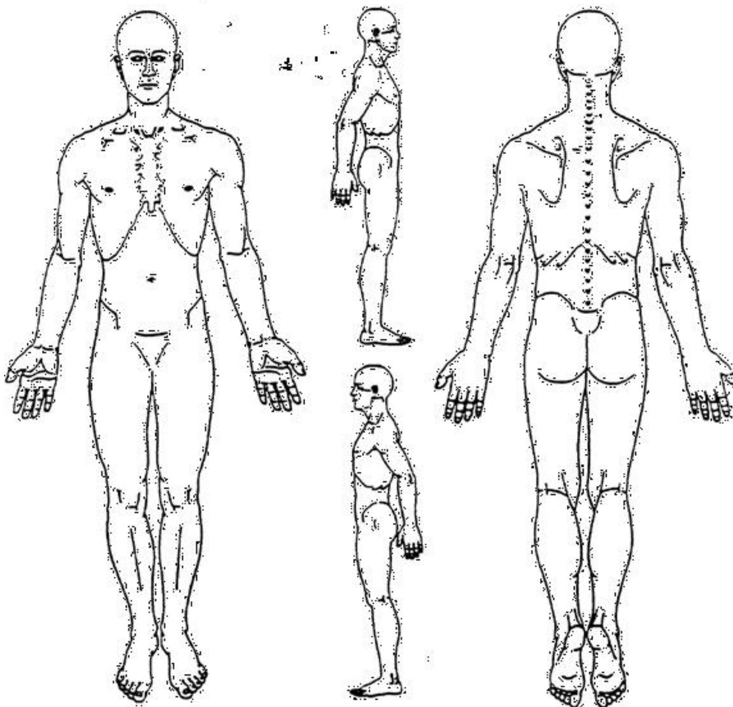
Allergy to topical antibiotic
Rapid heartbeat with epinephrine
Allergy to adhesive
Allergy to Lidocaine

Artificial heart valve
Artificial joints within last 2 years
Premedication prior to procedures
Blood thinners

Defrillator
Pacemaker
Pregnant, planning or nursing
Other:___________________

PLEASE DETAIL THE REASON FOR TODAY'S VISIT

Location: (Mark Site on chart below)



Problem: _______________________________________

Quality: Symptomatic Itch bleed tender scaly rough darker enlarging

Severity: mild moderate severe

Duration: How Long? __________________________

Previous Treatments:

(Lotions, OTC, Prescription or other?)

____

What makes it better or worse? __________________

Do you have any other rashes? YES or NO
Do you have any problems with allergy or your immune system? YES or NO
Do you have any stress? YES or NO, If yes, how significant? ____
Do you have problems with scarring? YES or NO
Do you have problems with bleeding? YES or NO

***for patients using insurance*

Assignment of Benefits Form

I hereby irrevocably assign and/or convey directly to Nikko Dermatology and/or its contracted healthcare providers as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by Nikko Dermatology for today's treatment/services and future treatment/services, regardless of its managed care network participation status. This Assignment of Benefits shall apply to all insurance coverage, including but not limited to the Centers for Medicare and Medicaid Services, its intermediaries, carriers or administrative contractors, State Medicaid programs, or any other governmental or commercial insurance. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize Nikko Dermatology to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy(ies), and/or settlement information upon written request from Nikko Dermatology or its attorneys in order to claim such medical benefits. I authorize Nikko Dermatology to appeal any and all claim denials or rejections on my behalf.

I intend by this assignment and designation of authorized representative to convey to Nikko Dermatology all of my rights to claim the medical benefits related to the services, treatments, therapies, and/or mediations provided by Nikko Dermatology, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (Nikko Dermatology) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. Nikko Dermatology as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

I understand that if Nikko Dermatology is not paid in full by proceeds from any insurance policies then I may be responsible for all or part of the remaining balance due.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

Signature:____ Date:______________