

# Menlo Dermatology Medical Group Patient Information

Dr. Thomas E. Hoffman

Dr. Honor Fullerton Stone

Dr. Jodie L. Bogomilsky

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
(Last, First, Middle)  Male  Female

Address: \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

email \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed Social Security # \_\_\_\_\_

Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_

Student:  Full Time  Part Time Name of School \_\_\_\_\_

Members of family also patients in this office \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_ Primary Care Physician \_\_\_\_\_  
 Friend/Family  Physician

Parent, Spouse, or Responsible Party (If different from patient) \_\_\_\_\_

In Case of an Emergency, please contact \_\_\_\_\_ Phone: \_\_\_\_\_

## PLEASE PRESENT ALL INSURANCE CARDS TO THE FRONT DESK TO PHOTOCOPY

Name of Primary Insurance Company \_\_\_\_\_ Copay \_\_\_\_\_

Name of Subscriber (If different from patient) \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address (If different from patient) \_\_\_\_\_

Policy is  Through Employer  Individual

Subscriber's Date of Birth \_\_\_\_\_ Subscribers Social Security # \_\_\_\_\_

DO YOU GIVE OUR OFFICE PERMISSION TO DISCUSS YOUR MEDICAL INFORMATION WITH FAMILY MEMBERS?

Yes  No If yes, please provide name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone number \_\_\_\_\_

**RECEIPT OF NOTICE OF PRIVACY PRACTICES:** My signature below indicates I have been provided an opportunity to review my physicians Notice of Privacy Practices.

## PLEASE NOTE OUR BILLING AND INDICATE YOUR ACCEPTANCE OF THESE ITEMS BY SIGNING BELOW:

- We kindly request **24 hours cancellation notice** and reserve the right to charge a **fee** for missed appointments.
- You are responsible for charges applied to your deductible, coinsurance and copay amounts, as well as for non-covered services and cosmetic services.
- You are responsible for payment of services when the required authorization and current insurance ID card are not presented at the time of service.
- You authorize payment of medical benefits to Menlo Dermatology Medical Group & Laser Center Inc.

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

Patient or Responsible Party Signature \_\_\_\_\_

Date \_\_\_\_\_