

Martin B. Miller, M.D.

14911 National Ave., Suite 5 • Los Gatos, CA 95032 • 408.356-2345 • Fax: 408.356-7307

Today's Date _____

Whom may we thank for referring you?
Who is your Family Doctor?
Patient / guardian e-mail address

PATIENT REGISTRATION

PATIENT INFORMATION: Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Dr. <input type="checkbox"/>				MARITAL STATUS			
Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>							
LAST NAME		FIRST		MIDDLE		SOCIAL SECURITY NO.	
ADDRESS				STREET, APT., P.O. BOX		CITY	
HOME PHONE NO.		EMPLOYERS NAME				OCCUPATION	
EMPLOYER'S ADDRESS				EMPLOYER'S PHONE NO.			
NEAREST LIVING RELATIVE (NOT LIVING WITH YOU)				ADDRESS		PHONE NO.	
DRIVER'S LICENSE NO.		WHOM MAY WE CONTACT IN CASE OF EMERGENCY?				PHONE NO.	
PREFERRED PROVIDER ORGANIZATION (PPO) ARE THOSE INSURANCE COMPANIES WHICH OFFER A PANEL OF PHYSICIANS TO SELECT FROM. IF YOUR INSURANCE COMPANY IS A PPO, PLEASE CHECK THIS BOX <input type="checkbox"/> . WHAT IS THE AMOUNT OF YOUR CO-PAYMENT FOR OFFICE VISIT: _____							
RESPONSIBLE PARTY - INSURED'S INFORMATION:							
PRIMARY CARRIER INFORMATION: Patient's relationship to insured: self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/>							
LAST NAME		FIRST		MIDDLE		SOCIAL SECURITY NO.	
ADDRESS				STREET, APT., P.O. BOX		CITY	
HOME PHONE NO.		EMPLOYERS NAME				OCCUPATION	
EMPLOYER'S ADDRESS				EMPLOYER'S PHONE NO.			
INSURANCE COMPANY				GROUP NO.		POLICY ID NO. - SUBSCRIBER NO.	
ADDRESS				STREET, P.O. BOX		CITY	
				STATE		ZIP	
SECOND INSURANCE INFORMATION:							
Patient's relationship to insured: self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/>							
LAST NAME		FIRST		MIDDLE		SOCIAL SECURITY NO.	
ADDRESS				STREET, APT., P.O. BOX		CITY	
HOME PHONE NO.		EMPLOYERS NAME				OCCUPATION	
EMPLOYER'S ADDRESS				EMPLOYER'S PHONE NO.			
INSURANCE COMPANY				GROUP NO.		POLICY ID NO. - SUBSCRIBER NO.	
ADDRESS				STREET, P.O. BOX		CITY	
				STATE		ZIP	
Please fill out information on reverse side							

MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made to the physician/supplier for any services furnished by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, My signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature _____

Date _____

(OVER →)

MEDICAL HISTORY - Please answer all questions

(Your nurse will go over this information with you in the examination room)

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	Yes	No		Yes	No
Good general health now	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>	Internal cancer	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Boils	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Food allergies	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Allergy to local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>

Women Only:

	Yes	No
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Expected delivery date	_____	
Are you breast feeding?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>
Which Brand?	_____	

What diseases, if any, run in your family? _____

Please list all prescription and non-prescription medications you are taking or have taken recently: _____

If you are allergic to any medications, please list them: _____

	Yes	No
Have you ever taken Penicillin?	<input type="checkbox"/>	<input type="checkbox"/>
Did you ever have a reaction to it?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been treated for skin cancer?	<input type="checkbox"/>	<input type="checkbox"/>

Previous skin problems _____

Serious illness _____

Hospitalizations _____

Surgery _____

CONSENT FOR TREATMENT OF MINOR

(Anyone under 18 years of age)

For a minor: I consent to have Dr. Miller or his associates provide medical care for _____

(name of patient)

in my absence. I would or would not like to be consulted prior to minor procedures such as mole removal, acne treatment and wart treatments. (circle one)

(Signature of Parent or Guardian)

(Witness)

ALL PATIENTS PLEASE SIGN

RELEASE AUTHORIZATION / ASSIGNMENT OF BENEFITS:

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED PHYSICIAN OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

THE INFORMATION ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Martin B. Miller, M.D. FAAD
Diseases and Surgery of the Skin

Financial Policy

Thank you for choosing us as your skin care provider. We are committed to providing you with the best dermatologic care available. The following is a statement of our Financial Policy. *Please read carefully and sign to acknowledge your understanding and agreement.*

Insurance Plans in Which We Are a Participating Provider

For covered services, we ask that all co-payments and deductibles be paid on the day of treatment. For services that are not covered by your insurance, we ask that you pay the entire fee the day of your treatment.

At the time of your service, if we/you believe you have valid insurance coverage, but later find out, for whatever reason, you were not covered, you acknowledge and agree you are responsible for the entire fee.

Insurance Plans in Which We Are Not a Participating Provider

For those plans in which we are not a participating provider, or once were but are no longer, we ask that you pay the entire professional fee at the time of your visit.

Usual and Customary Fees

Our practice is committed to providing the highest level of professional care and service we can. Our fees are based on many factors including skill, care and judgment of our staff, quality of supplies and equipment, and our ongoing professional continuing education.

Insurance companies may arbitrarily determine a "geographic usual and customary fee." Any insurance company determination of what is usual and customary will not impact the quality of care you receive so you will be responsible for our entire professional fee (Does not apply to *covered* services for insurance plans in which Dr. Miller is a participating provider).

Unpaid Accounts

Accounts unpaid over 30 days may be subject to a monthly finance charge. Accounts unpaid over 90 days will be considered delinquent and may be subject to collection procedures. If your balance becomes delinquent and collection procedures become necessary, you are responsible for all the collection costs, court costs, and/or attorney's fees incurred by Dr. Miller and/or his staff or representatives.

Missed Appointments/Late Cancellations

There may be a charge for missed appointments unless 24-hour advance notice is given. (\$50 for office visits; will be higher for missed surgical procedures.)

I have read the above paragraphs and understand their contents and agree to the provisions stated in them.

Patient's signature

Date

Print name