Welcome to our office. Please fill out this form completely.

Patient Name: _____ Nickname: _____

Home Address: _____ City: _____ ZIP: _____

Home Phone: _____ Birthdate: _____ Age: _____ Sex: _____

Email Address: _____

Name of Parent/Legal Guardian: _____

Patient's Primary Physician: _____

Referred By: _____

Employer: _____

Work Address: _____ Work Phone: _____

Soc. Sec. # (If Insur. Requires): _____ Cell Phone: _____

Marital Status: _____ Spouse: _____

Phone: _____ Birthdate: _____ Age: _____ Sex: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

If someone other than patient is responsible for payment, complete below.

Name: _____ Phone: _____

Home Address: _____ Soc. Sec. #: _____

Insurance Information

Primary Carrier: _____ Co-Payment: _____

Secondary Carrier: _____ Co-Payment: _____

As patient or as legal guardian of minor patient, I agree to pay for all services rendered. This office may bill my insurance carrier as needed. ASSIGNMENT & RELEASE: I hereby assign my insurance benefits to be paid directly to Dr Kristin Walker, M.D., INC. I am financially responsible for non-covered services. I authorize the physician to release any information necessary to process this request.

Date: _____ Signed: _____

All Medicare patients must sign a lifetime beneficiary claim authorization: I request that payment of authorized Medicare benefits be made either to me, or on my behalf to Dr. Kristen Walker, M.D., Inc. for any services furnished to me by that physician.

Date: _____ Signed: _____

Kristin Walker, M.D., Inc. 89 Davis Road, Suite 180, Orinda, CA 94563

Kristin Walker, M.D.

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

*Conduct, plan, and direct my treatment and follow-up among the various healthcare providers who may be involved in that treatment directly and providers who may be involved in that treatment directly and indirectly.

*Obtain payment from insurance companies and/or third party payers.

*Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by this office of their "Notice of Privacy Practices" containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such "Notice of Privacy Practices" prior to signing this consent. I understand that this office has the right to change its "Notice of Privacy Practices" from time to time, and that I may contact this organization at any time at the address below to obtain a current copy of the "Notice of Privacy Practices".

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

In addition to the above, I also consent to the following items:

____YES____NO Allow messages to be left on my answering machine regarding my health information (i.e. test results, appointment confirmations and appointment follow-up issues)

____I do not have an answering machine

____YES____NO Leave message with person who answers your phone if you are not available

____YES____NO Allow appointment reminders and recall notices to be sent by postcard in the mail

____YES____NO Allow appointment scheduler to verbally communicate my next appointment and/or tests information at the checkout desk

PATIENT NAME:_____

SIGNATURE:_____

RELATIONSHIP TO PATIENT:_____

DATE:_____

PATIENT HISTORY FORM

All information contained below is confidential

NAME:_____ DATE:_____

FAMILY M.D.:_____OCCUPATION:_____

CURRENT MEDICATIONS (incl. topical and over-the-counter)

_____ _____

_____ _____

_____ _____

ALLERGIES TO MEDICATIONS

_____

Have you ever been diagnosed with skin cancer? _____ If so, what kind and where was it located? _____

_____

Have you ever been diagnosed with melanoma? _____ If so, what level and where was it located? _____

Have you ever been treated for skin problems other than at our office? ____
If yes, please describe condition and treatment _____

_____

_____

Please specify family members who have been treated for

Melanoma_____
Skin Cancer (other than melanoma)_____
Lupus_____
Psoriasis_____
Eczema/Atopic dermatitis_____
Asthma_____
Hayfever/Seasonal allergies_____
Other skin conditions (please explain)_____

____ Check here if you take blood thinners
____ Check here if you take antibiotics before surgery or dental procedures
____ Check here if you have an artificial heart valve or artificial joints
____ Check here if you have a pacemaker or defibrillator
____ Check here if you form thickened scars or keloids
____ Check here if you have ever had or have hepatitis

Please list any illnesses for which you have been treated within the last 5 years:

_____

_____

_____

Please list any prior hospitalizations and surgeries with approximate dates:

_____

_____

_____

Do you smoke? _____ How frequently? _____

Do you drink alcohol? ___ How frequently? _____

Please circle YES or NO if you have been treated or are being treated for any of the following

Heart Disease	YES	NO
Chest Pain	YES	NO
Shortness of Breath	YES	NO
Lung Disease	YES	NO
Arthritis	YES	NO
Diabetes	YES	NO
Epilepsy	YES	NO
Stomach Ulcers	YES	NO
Colitis	YES	NO
Kidney Disease	YES	NO
Liver Disease	YES	NO
Eye Disease (glaucoma)	YES	NO
Cancer	YES	NO
Blood Clots/Strokes	YES	NO
Emotional/Psychiatric	YES	NO
Frequent infections	YES	NO
Thyroid Disease	YES	NO
Tuberculosis	YES	NO