PATIENT DEMOGRAPHIC FORM 3300 WEBSTER ST. #1106 OAKLAND, CA 94609

Patient Name: _____

Responsible party (if minor): _____

DATE OF BIRTH: _____ Sex: Male/Female

LANGUAGE: _____ ETHNICITY: _____ Marital Status: _____

Contact information:

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Wk #_____ Cell #_____

e-mail: _____ *Please note; our E-mail and text messaging are not secure* ~Is it okay to leave message/email with confidential results? Yes or No. If yes □ hm □ wk □ cell □ e-mail ~I certify that I understand the privacy risk of the mail, phone calls, e-mail and text messaging. I hereby authorize Dr. Michael Cedars, Dr. Tomi Wall, Dr.Katie Rodan or their, representative to mail, call, e-mail and or, a text message me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and lab results.*Is it okay to talk to whoever answers the phone with confidential results? Yes or No if yes □ hm □ wk □ cell

Emergency Contact: _____ Relationship: _____ Phone #_____

Primary Care Physician: _____ Phone# _____

OCCUPATION: _____ Employer Name:_____ _____

WHO REFERRED YOU TO OUR OFFICE? _____

PLEASE PRESENT ALL INSURANCE CARDS TO FRONT DESK TO PHOTOCOPY

Primary Insurance Company name: _____

Name Of Insured (if different from Patient): _____

SS#:_____ **DOB:**_____ **Sex:**_____ **Marital Status**_____

Relationship to Patient: _____ **Policy is through: employer / individual**

What is your co-payment? _____

Secondary Insurance Company Name: _____

Insurance ID #:_____

By signing below, I agree to communicate with the office as described above. We will bill your insurance for medical services as a courtesy. Any unpaid balance is your responsibility. At the time of the visit, you must pay unmet deductible and co-payments and for non-covered medical services and all cosmetic services.

Patient Signature: _____ **Date:** _____

Name: _____ **Date:** _____

Height:_____ **Weight:** _____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH (Benign prostatic hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid Reflux)
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA (Angioplasty)
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Transurethral Resection of the Prostate)
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None
Other _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None
Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma?
Mother Yes No
Father Yes No
Sibling Yes No
Other: _____

Medications: (Please enter all current medications)

_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____

Pharmacy Name: _____
Address: _____
Phone #: _____

Social History: (Please circle all that apply)

Cigarette Smoking:
- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Alcohol Use:
- Alcohol: none
- Alcohol: less than 1 drink a day
- Alcohol: 1-2 drinks a day
- Alcohol: 3 or more drinks a day

Illicit Drug Use:
- Drug Use
- IV Drug Use

Safety:
- I feel safe at home.
- I do not feel safe at home

Other_____ None

Review of Systems: Are you currently experiencing any of the following?
(please check yes or no for the following)

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic or keloid)		
Immunosuppression		
Changing mole		
Rash		
Abdominal pain		
Anxiety		
Bloody stool		
Bloody urine		
Blurry vision		
Chest pain		
Cough		
Depression		
Fever or chills		
Headaches		
Hay fever		
Joint aches		
Muscle weakness		
Neck stiffness		
Night sweats		
Seizures		
Shortness of breath		
Sore throat		
Thyroid problems		
Unintentional weight loss		
Wheezing		

Other Symptoms: _____

Alerts: Do you have any of the following? (please check yes or no for the following)

Alert	Yes	No
Pacemaker		
Artificial joints within past two years		
Artificial heart valve		
Premedication prior to procedures		
Defibrillator		
Allergy to adhesive		
Allergy to topical antibiotic ointments		
Blood thinners		
Pregnancy or planning a pregnancy		
Allergy to lidocaine		
Rapid heart beat with epinephrine		
Yeast infections with antibiotics		
GI upset with antibiotics		

Other Symptoms: _____

MICHAEL G. CEDARS, M.D., FACS, Inc.
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TOMI LEE WALL, M.D., F.A.A.D.
JUDE ROWE, R.N.

3300 Webster Street, Suite 1106 Oakland, CA 94609
PHONE: (510) 763-2662
FAX: (510) 763-2679

HIPAA NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practice. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of the amended Notice of Privacy Practice will be available at each appointment.

□ I would like to receive a copy of any amended Notice of Privacy by e-mail at:
_____

Signed: _____Date:_____

Patient Name: _____Telephone:_____

If not signed by the patient, please indicate relationship:

□ Parent or guardian of minor patient

□ Guardian or conservator of an incompetent patient

Name and Address of patient:

_____

_____

Michael G. Cedars, M.D., FACS, Inc.
Katie P. Rodan, M.D., A.P.C
Tomi Lee Wall, M.D., F.A.A.D.
Jude Rowe, R.N.
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Phone: (510) 763-2662
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We welcome you as a patient. We appreciate the opportunity to serve you.

Prior to your appointment please advise us if there have been any changes in your address, e-mail, phone number, or insurance coverage. Most insurance companies allow only a three-month time frame to submit claims. As a courtesy we will submit non-cosmetic bills to your insurer if you wish. It is the patient's financial responsibility to ensure that your personal information that may appear on those bills is accurate and current.

All medical patients must provide insurance information and referrals, or your appointment may be rescheduled. It is your responsibility to confirm that your physician is a participating provider with your insurance plan.

Some of our cosmetic treatments require a deposit at the time of scheduling an appointment. Additional charges may apply when cosmetic and medical evaluation/treatment are done at the same visit.

Please note: Our office requires a 24-hour notice if you cannot make your scheduled appointment. There will be a minimum $50.00 no-show fee, which may be higher based on the amount of time reserved for you.

Due to the high volume of requests, please allow 72 hours for your prescription to be approved and reach the pharmacy.

E-mail is intrinsically not a secure form of communication.

Patient complaints may be directed to the physician or our office manager.

_____	_____	_____
Patient Signature	Print Patient Name	Date
_____	_____	_____
Witness Signature	Print Witness Name	Date