Coronado Dermatology

Charlene V. Kakimoto M.D. –Jacqueline L. Brogan M.D.- Nathan S. Uebelhoer D.O.

-Intake and History Form-

Name: ________________________ Date of Birth: ____________ Today's Date: __________________________

Address: ______________________________ City/State: ______________________________ Zip Code: _______________

Phone Number (day): __________________________________ Gender: ________________

Email: ____ Preferred Language: ____________________

Past or present Occupation: ______________________________________ Employer: _________________________________

Person Responsible for bill IF DIFFERENT from above: ____

Phone Number: ____________________________ Relationship to Patient: ____

INSURANCE

Company Name: ____________________________________ Member # ____

Supplemental/Secondary: ____

PCP: _____________________________________ and/or Referring Physician: ______________________________________

For TRICARE Insurance Only – required for billing on all Tricare Plans

Sponsor Name: ______________________________ D.O.B: ________________ Social Security #: ____________________

REASON FOR VISIT:

____

Are you interested in cosmetic treatments?: ☐ Botox ☐ Fillers ☐Laser ☐ Chemical Peel ☐ Micro needling ☐ Other:
____

Allergies and Reactions: ____

Medication List:

Medication Name	Dosage	Last Taken	Reason

Preferred Pharmacy: ____

SKIN DISEASE HISTORY

Have you had any of the following? Check all that apply

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ 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 have a family history of Melanoma?

☐ YES ☐ NO If yes, which relative:______________

Do you wear sunscreen: ☐ YES ☐ NO

SPF: _______________

Do you tan in a tanning salon: ☐ YES ☐ NO

MEDICAL HISTORY

Have you had any of the following? Check all that apply

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Cancer If yes what type______________________
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ OTHER ___________________________________

SURGICAL HISTORY:

Have you had surgery on any of the following areas?

☐ Heart: Coronary Artery Bypass Surgery ☐ Heart: Transplant ☐ Heart Mechanical Valve Replacement

☐ Joint Replacement Hip: ☐ Right ☐ Left ☐Bilateral Date of Surgery: _____________________________

☐ Joint Replacement Knee: ☐ Right ☐ Left ☐Bilateral Date of Surgery: _____________________________

Do you require antibiotics prior to surgical/dental procedures: ☐ YES ☐ NO

Patient/Responsible Party signature: ____ Date: ______________________

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Acknowledgement Form

-Acknowledgement of Receipt of Notice of Privacy Practices-HIPAA, and OFFICE/BILLING POLICIES
I have been provided a copy for review, either electronically or printed form, of the **HIPPA, OFFICE AND BILLING POLICIES** for the medical practice of Charlene V. Kakimoto M.D., Jacqueline L. Brogan M.D., and Nathan S. Uebelhoer D.O.

-I hereby consent to, and authorize my doctor (Dr. Charlene V. Kakimoto, Jacqueline L. Brogan, Dr. Nathan S. Uebelhoer, (and/ or authorized physicians covering in the absence) to examine me and, render medical treatment for my health condition (s), that in the judgment of my doctor may be considered advisable or necessary.

-I am responsible for payment for all non-cover services at the time of service. I also accept responsibility for non-covered services denied by my insurance company.

-I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits to the party who accepts assignment . I authorize payment of medical benefits to the physician (Charlene V Kakimoto M.D., Jacqueline L. Brogan M.D., Nathan S. Uebelhoer D.O.) for services rendered. I also request payment of my employer's/ government's health Insurance benefits to my secondary Insurance.

-I understand that as a condition to care at this office, in the unlikely event that the doctors or assistant get stuck with needle or surgical instruments used on me during the course of, or immediately after, any injections or procedures that may require, the above signature also serves as my consent to have my blood tested for Hepatitis B, hepatitis C, HIV and other pertinent infectious diseases.

WAYS OF CONFIDENTIAL COMMUNICATIONS:
Please list all methods you prefer to be contacted by regarding your medical condition or treatment:

Home: __________________Work: ______________________ Cell:_________________________
May we have your permission TO LEAVE A DETAILED MESSAGE ON VOICEMAIL/MACHINE: YES ____NO____
If we must contact you, and you are not available, we have your permission to discuss treatment and care with (list all):
1)____
2)____
3)____

EMERGENCY CONTACT:____
PHONE:__________________________RELATIONSHIP TO PATIENT:_____________________________

NAME OF PATIENT:___________________________

SIGNATURE:________________________________DATE:_________________________________

Minor/adult unable to sign for themselves:____

Signature of Representative:____
Relationship to patient:____

PATIENTS NAME (Print) :____
PRIMARY CARE DOCTOR:____________________

Annual Medicare Quality Payment Program (QPP) Questionnaire: 2024

We are asking these questions to be in compliance with our contract to see people with Medicare insurance. It is your right to leave any questions blank. Please sign and date below.

1. Advanced Directives

Advanced Directives are designed to respect your wishes about future life sustaining treatments, in the event that you are unable to communicate.

Which statement(s) **best reflect** your wishes on **Advanced Care**?

__I want full cardiopulmonary resuscitation efforts to be made
(FULL CODE)

__I do not want a breathing tube, even if it is needed to save my life
(DO NOT INTUBATE)

__I do not want chest compressions or a defibrillator to restart my heart
(DO NOT RESUSCITATE)

Which statement best reflects your **Advanced Directive Status**?

__I have a living will

__I have a health care proxy whose name is ______________________

__The contact information for my health care proxy is:______________

2. Melanoma Recall

It is recommended that those with a history of melanoma have a melanoma skin exam, at least once a year

__I have a history of melanoma

3. Psoriasis

It is recommended that we discuss your goals for clear skin

__I have a history of psoriasis

4.Unhealthy Alcohol use: Screening and Brief Counseling (age 65 years and older)

Men: How many times in the past year have you had **5+** drinks in a day?______

Women: How many times in the past year have you had **4+** drinks in a day?______

5. Smoking Status

__Current smoker __#packs per day

__Former smoker

__Non-smoker

______________________________ ____________
Signature Date