PATIENT INFORMATION SHEET

Patient Name:

Date of Birth:

Primary Doctor:

MEDICATION LIST: *(please include vitamins/supplements)*

If you carry a personal list of medications, we can Xerox it and attach it for you.

If your doctor is part of Sharp Community Medical Group (SCMG) and you are registered on Follow My Health you do not need to fill in your medications as we have online access to them.

Does your doctor ask you to take antibiotics before surgery? ☐ Yes ☐ No

ALLERGIES to any medications? ☐ Yes ☐ No If Yes, to what? _____

Do you have allergies to tape, latex or iodine? ☐ Yes ☐ No

MEDICAL HISTORY

Do you have any of the following conditions (check all that apply) *or* ☐I don't have any medical problems

☐ Anemia	☐ Arthritis	☐ Artificial heart valve	☐ Artificial joints	☐Asthma
☐ Cataracts	☐ Cholesterol (high)	☐ Crohn's disease	☐ Diabetes	☐ Gastric reflux
☐ Glaucoma	☐ Heart disease	☐ Heart murmur	☐ Hepatitis	☐ High blood pressure
☐ HIV	☐ Kidney problems	☐ Keloids	☐ Lupus	☐ Radiation therapy
☐ Pacemaker	☐ **PREGNANCY**	☐ Thyroid disorder	☐ Ulcers	☐ Transplant Organ: Year:

☐ **OTHER**: _____

SURGERIES? What/When:

_____

Have you ever had a SKIN CANCER? ☐ Yes ☐ No *(If Yes, please indicate where and approximately what year)*

If yes? ☐ Basal cell ☐ Squamous cell ☐ Melanoma ☐Don't know

FAMILY HISTORY ☐Melanoma ☐Basal cell skin cancer ☐Squamous cell skin cancer If yes, who?_____

Other skin illnesses: ☐ Eczema ☐Psoriasis ☐ Lupus ☐ Autoimmune Disease or problems that run in family?

There's more—please go on to next page. Thanks!

REVIEW OF SYSTEMS: Please check all of the conditions **you currently have or check ( ) NONE**

Constitutional:	☐Fever ☐Unexplained weight loss
Gastrointestinal:	☐Nausea ☐ Vomiting ☐Diarrhea ☐Constipation ☐Eating problems
Genitourinary:	☐ Frequency ☐Burning ☐Difficulty ☐Irregular menstrual periods
Endocrine:	☐Excess thirst ☐Hormone problems
Lungs/Respiratory:	☐Shortness of breath ☐Problems breathing
Cardiovascular:	☐Chest pain ☐Palpitations ☐Ankle swelling
Ear/Nose/Throat	☐Hearing aid ☐Hearing problem ☐Ringing in ears ☐Ear infections ☐ Problems swallowing
Pregnancy issues:	☐Currently pregnant ☐Planning pregnancy ☐Currently breast feeding
Lymph/Hematology	☐ Abnormal bleeding ☐ Swelling of glands ☐Clotting problems
Eyes:	☐ Contact lenses ☐Blurred vision ☐Vision problem
Musculoskeletal	☐Joint pain ☐Back pain
Allergy/Immunology	☐ Seasonal allergies/Hayfever
Neurological	☐Migraines ☐Numbness ☐Seizures
Psychiatric:	☐Depression ☐Anxiety

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No If yes, how much per day? _____ For how many years? _____

How much alcohol do you drink per week? ☐ None ☐ Rarely ☐less than 14 drinks/week ☐ more than 14 drinks per week

Your occupation: _____ ☐Retired

Spouse's/Significant other's occupation (if applicable) _____ ☐Retired

Marital status ☐ Married ☐ Not married ☐ Significant Other ☐ Divorced ☐ Widowed

Anything else you would like to share?

Patient Signature: _____ **Date:** _____

Thanks for filling this out! We know that the paperwork is a pain but we do appreciate it!

Reviewed by: _____ **Date:** _____

Dermatology Office of Dr. Mona Z Mofid & Juan Kojima, PA-C
8929 University Center Lane Suite 202
San Diego, CA 92122
858-412-3271

I hereby acknowledge that Mona Z Mofid, MD has provided me with an explanation of her Notice of Privacy Practices in compliance with the HIPAA Patient Privacy Act.

I understand my rights regarding the handling of my Protected Health Information as a patient of Mona Z Mofid, MD.

Mona Z Mofid, MD is participating in San Diego Health Connect to better coordinate our patient's healthcare through the sharing of clinical information.

By default, all records of Mona Z Mofid, MD are included in San Diego Health Connect. If you do not want your information shared, please check the box below:

☐ No

Patient's Signature: _____

Date: _____

Open Payments database

Pursuant to California Assembly Bill (AB) 1278, as of January 1, 2023 physicians are required to provide notice to new patients regarding the Open Payments database (Database), which is managed by the U.S. Centers for Medicare & Medicaid Services, or CMS.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

Acknowledged

_____ _____
Patient signature Date signed

No Show Policy

Any patient who has confirmed an appointment and fails to cancel that appointment with at least 24 hours' notice, will not be rescheduled without incurring a $75 "no-show fee." The no-show fee must be paid prior to the office rescheduling the appointment. Failure to show up for two appointments without cancelling 24 hours in advance may result in being dismissed from the practice.

_____ _____
Patient signature Date signed

Copy provided to patient _____ *(staff member initials and date)*

CONFIDENTIAL PATIENT INFORMATION

Last Name	First Name	MI	Birth Date	Today's Date	Patient Acct

Address	City	State	Zip Code	MRN

Home Phone: Work Phone:	Mobile Phone: Email:	Gender	Social Security #

Language: **English**
Please select one:

□ English □ Greek □ Vietnamese
□ Spanish □ Italian □ Tagalog
□ French □ Japanese □ Russian
□ Arabic □ Korean □ Cambodian
□ Chinese □ Mandarin □ Laotian
□ German □ Persian □ Other

Race: **White**
Please select one race that closely identifies you:
□ Asian
□ American Indian or Alaskan Native
□ Native Hawaiian or Other Pacific Islander
□ Black or African American
□ White
□ Declined to answer
□ Unknown

Additional Race:
Please select one additional race that closely identifies you:
□ Asian
□ American Indian or Alaskan Native
□ Native Hawaiian or Other Pacific Islander
□ Black or African American
□ White
□ Declined to answer
□ Unknown

Ethnicity **Unknown**
Hispanic or Latino- *A person of Cuban, Mexican, Puerto Rican, South or Central America, or other Spanish culture or origin regardless of race.* ***Please select:***

□ Hispanic or Latino □ Non-Hispanic or Latino
□ Decline to answer □ Unknown

Marital Status: **Married**

Employer:
Employer Address:

Emergency Contact	Home Phone	Work Phone	Relationship to Patient

PLEASE COMPLETE THE FOLLOWING SECTION IF GUARANTOR IS DIFFERENT FROM PATIENT

Last Name	First Name	MI	Relationship to Patient	

Address	City	State	Zip Code

Home Phone: Work Phone:	Social Security #	Birth Date	Gender

Employer's Name	Employer's Address:

PRIMARY INSURANCE

Insurance Name: **SCP2 SCMG UHC Medicare Advantage**	
Claims Address	CoPay
City, State, Zip	Ins Ph. No.
Subscribers Name	Gender M ☐ F ☐
Subscribers ID	Group No.
Subscribers Birth Date	Effective Date
Patient's Relation to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐	

SECONDARY INSURANCE

Insurance Name:	
Claims Address	CoPay
City, State, Zip	Ins Ph. No.
Subscribers Name	Gender M ☐ F ☐
Subscribers ID	Group No.
Subscribers Birth Date	Effective Date
Patient's Relation to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐	

I authorize payment of my medical benefits be made directly to my physician for services rendered. I authorize any insurance company, organization, employer, hospital, physician, or pharmacist to release any information necessary related to my medical care and to facilitate payment of my medical expenses owed my physician.

_____ _____

SIGNED (Insured or Authorized) ***DATE***