cmk | carolyn kassabian, md inc.
medical & cosmetic dermatology
14901 Rinaldi St #305
Mission Hills, CA
818.838.6070
6310 San Vicente Blvd.
Suite 220. LA, CA 90048.
424.571.6670

PATIENT INFORMATION

Date: _____/_____/_____ Medication Allergies: _____

Last Name: _____First Name: _____ Middle Initial: ____

Age: _____ Date Of Birth: _____/_____/_____

Home Address: _____

City: _____State: _____Zip: _____

Home Phone: (____) _____-_____

Cell Phone: (____) _____ - _____May we leave message reg. your medical info. Yes or No

Email Address: _____

Social Security #: _____ - _____ - _____

Marital Status: Single Married Divorced Widowed

Occupation: _____ Work Phone: (_____) _____ - _____

Primary Care Physician: _____ Referred By: _____

Pharmacy Name: _____City:_____Street:_____

Emergency Contact: _____ Phone: (_____) _____ - _____

Can we disclose any medical information to family? Yes or No

1. Name_____ Relationship_____
2. Name_____Relationship_____

If patient is under the age of 18 or under the care of a legal guardian, Name of Responsible Party _____

Skin type: FAIR MEDIUM DARK (Circle One)

Ethnicity: _____Place of Birth: _____

How many sunburns have you had since childhood? _____

Do you use sunscreen? _____ What Brand of sunscreen? _____SPF:_____

Do you work outdoors? _____

GENERAL HEALTH QUESTIONS:

Are you prone to or do you have any of the following conditions: PLEASE CIRCLE

Yes	No	Smoker	Yes	No	Autoimmune condition
Yes	No	Oral Herpes	Yes	No	Radiation treatment
Yes	No	Tendency to bleed	Yes	No	Difficulty with wound healing
Yes	No	Diabetes	Yes	No	High blood pressure
Yes	No	Heart problems	Yes	No	Depression or mental illness
Yes	No	Hepatitis or HIV	Yes	No	Liver/Kidney Disease
Yes	No	Anemia	Yes	No	Visual or Hearing Problems
Yes	No	Respiratory Problems	Yes	No	Sexually transmitted disease

Yes No Other:_____

If you answered YES to any of the above questions, please explain:

_____

_____

We specialize in a number of cosmetic procedures. Are you also interested in scheduling a consultation for any of the following? PLEASE CIRCLE

YES NO Laser treatment for hair reduction, broken blood vessels or brown spots

YES NO Treatment of deep wrinkles with Restylane, Juvederm, Skin Rejuvenation, Radiesse

YES NO Botox treatment of frown lines or crow's feet

YES NO Spider (leg) vein treatment

DERMATOLOGY-RELATED HEALTH QUESTIONS:

YES NO Previously diagnosed skin condition

Previous Dermatologist: _____ If Yes, what condition(s)?_____

YES NO History of skin cancer: Basal cell, squamous cell, melanoma (Please Circle)

If yes, Please Provide dates and details:

_____

YES NO History of pre-cancers.

YES NO Family history of skin cancer: Basal cell, squamous cell, or melanoma (Please Circle)

YES NO History of eczema, allergies or hay fever

MEDICAL HISTORY:

Reason for Today's Visit: _____

Medical Illness or conditions: _____

Previous Operations: _____

Current Medications: (Including over the counter products and vitamins).

_____

_____

_____

_____

(FEMALE PATIENTS ONLY)

Are you currently pregnant or breast feeding? Yes No (Please circle)

Subscriber Information: (IF DIFFERENT FROM PATIENT)

Last Name:_____ First Name:_____

DOB:_____ Relationship to Patient:_____

Address (If different from Patient) :_____

City: _____ State:_____ Zip Code:_____

Phone Number: _____

Kassabian Financial Policy

Payment is expected at the time of service(s) for any part of the charges that is your responsibility. "Your responsibility" varies depending upon your insurance plan. Please read the information below as it applies to your insurance coverage:

Private Pay: Payment for all services provided is due and payable at the time of service. If paying by check, there will be a $30.00 charge for all checks returned for insufficient funds.

HMO/PPO's (Such as Motion Picture, Blue Cross, Blue Shield, etc.) You are expected to pay the co-payment defined by your plan upon arrival at the office. You are also responsible for payment of any deductible amounts and non-covered services upon exit. You will be billed for any amount due after insurance has paid. Prompt payment is then expected. Also, there may be a separate charge to an outside laboratory that you will be responsible for as well.

Cancellation policy: You agree to accept responsibility for the office visit charge of $40.00 if you fail to give 24 hours notice prior to your appointment.

Medicare: You are responsible for 20% of Medicare's approved amount unless you provide our office with secondary insurance coverage at the time of your service.
Medigap/ Crossover Plans: If you're covered by Medicare and you have a Medigap policy or are covered by a plan to which Medicare automatically crosses over the claim, you are responsible only for any unpaid deductibles you may have not yet paid.
We ACCEPT MOST MAJOR CREDIT CARDS FOR YOUR CONVENIENCE.

I have read the above, and I understand my financial obligation to Dr. Carolyn Kassabian, and I agree to abide by the terms stated above.

Signature of Patient or Legal Guardian: _____ Date: _____