Howard L. Sofen, M.D.

PATIENT INFORMATION

NAME:		**SEX:** ☐ Female ☐ Male	**BIRTH DATE:**	**SOCIAL SECURITY NO.:**
ADDRESS:	**APT:**	**CITY:**		**STATE / ZIP CODE:**
PRIMARY PHONE: ☐ Cell ☐ Home ☐ Work	**SECONDARY PHONE:** ☐ Cell ☐ Home ☐ Work			**REFERRED BY:**
EMPLOYER:	**EMAIL ADDRESS:**			**MARITAL STATUS:** ☐ Single ☐ Divorced ☐ Married ☐ Widowed

OTHER CONTACTS

Emergency Contact	NAME:	RELATIONSHIP:	PHONE:
Responsible Party	NAME:	RELATIONSHIP:	PHONE:
	ADDRESS:	CITY:	STATE / ZIP CODE:

INSURANCE INFORMATION

Primary	COMPANY NAME:	TYPE:	ID NO:
	INSURED'S NAME:	RELATIONSHIP:	GROUP NO:
Secondary	COMPANY NAME:	TYPE:	ID NO:
	INSURED'S NAME:	RELATIONSHIP:	GROUP NO:

PATIENT PRIVACY INFORMATION

I hereby authorize Howard Sofen and staff to communicate medical information pertaining to my care through the following methods: ☐ Cell phone ☐ Work Phone ☐ Home phone ☐ Email

I hereby authorize Howard Sofen and staff to communicate medical information pertaining to my care to a referred or referring healthcare provider. I assume responsibility to notify the office should any of this information change in the future.

_____
Signature

Please list the names of people, if any, our staff can discuss your medical care with:

NAME:	PHONE:	NAME:	PHONE:

I acknowledge that the above information is true and correct.

_____ _____
Signature Date

Howard L. Sofen, M.D.

Office Policies

PAYMENT POLICY

- All copayments and deductibles are due at the time of service. All previous balances must be cleared at the time of service.
- Patients are responsible for paying all balances not paid by the insurance carrier.
- We accept cash, checks, and credit cards (MasterCard, Visa, and American Express) for all payments. ATMs are accessible next door or across Sepulveda Blvd.
- If insurance coverage has been terminated prior to the time of service, patients are responsible for all charges incurred.
- All balances owed by patients which are not paid after 120 days will be sent to collection.
- A $25.00 fee will be imposed for returned checks. Payment must be made within 10 days to avoid collection's actions.

HMO PATIENTS

- Patients are responsible for obtaining and bringing proper authorization *prior* to their visit.
- HMO insurance will not cover your visit without appropriate authorization. If no authorization is present, patients can be seen on a cash basis, but will not be reimbursed for the charges.

MEDICAL NECESSITY

- If the insurance carrier determines that a particular service is not medically necessary under their policy guidelines, they will deny payment for that service.
- The criteria for medical necessity are at the discretion of the insurance carrier and can change at any time.
- Patients are responsible for verifying coverage with their insurance carrier. Our staff can only give general information about what is *usually* covered by most carriers.
- The care your provider believes is medically necessary may not be considered a medical necessity or may not be a covered benefit under your plan.

APPOINTMENTS

- If you are unable to make an appointment at your scheduled time, please advise us at least 24 hours in advance. We will assist you with a reminder call on the day before your appointment.
- While we understand that unforeseen circumstances may require a last minute cancellation/postponement, we reserve the right to charge for missed appointments or appointments cancelled with insufficient notice.
- We reserve the right to refuse to schedule an appointment for any patient after three failures to adhere to these policies.

_____ _____

Signature Date

Privacy Policies

Our practices' Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients' Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. A copy is available at the front desk. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor the agreement.

By signing this form, you acknowledge that you have been given the opportunity to review our Notice of Privacy Practices and you consent to our use and disclosure of protected health information about you for treatment, payment from your insurance company, and health care operations. You have the right to revoke this consent, in writing, signed by you. However such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996.

_____ _____

Signature Date

Name: _____ DoB: _____

Employment History

EMPLOYMENT AT THE TIME OF INJURY

EMPLOYER:	START DATE:	END DATE:
JOB DESCRIPTION:		

PREVIOUS EMPLOYMENT

EMPLOYER:	START DATE (MM/YY):	END DATE (MM/YY):
JOB DESCRIPTION:		

EMPLOYER:	START DATE (MM/YY):	END DATE (MM/YY):
JOB DESCRIPTION:		

EMPLOYER:	START DATE (MM/YY):	END DATE (MM/YY):
JOB DESCRIPTION:		

EMPLOYER:	START DATE (MM/YY):	END DATE (MM/YY):
JOB DESCRIPTION:		

Name: _____ DoB: _____

History of Current Injury

ACTIVITIES AT THE TIME OF INJURY

DATE OF INJURY:	DATE LAST WORKED:	TASK PERFORMED AT THE TIME OF INJURY:
HOW DID THE INJURY OCCUR:		

TREATMENT RECEIVED FOR DERMATOLOGICAL INJURY

PHYSICIAN NAME:	START DATE (MM/YY):	END DATE (MM/YY):
TREATMENTS ADMINISTERED / MEDICATIONS GIVEN:		
PHYSICIAN NAME:	START DATE (MM/YY):	END DATE (MM/YY):
TREATMENTS ADMINISTERED / MEDICATIONS GIVEN:		
PHYSICIAN NAME:	START DATE (MM/YY):	END DATE (MM/YY):
TREATMENTS ADMINISTERED / MEDICATIONS GIVEN:		

CURRENT DERMATOLOGICAL PROBLEM

CURRENT SYMPTOMS:
CURRENT LIMITATIONS:

Name: _____ DoB: _____

Past Medical History

MEDICAL HISTORY

Heart Disease	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Congestive heart failure	☐ Yes ☐ No	Seasonal Allergy / Hayfever	☐ Yes ☐ No
Peripheral vascular disease	☐ Yes ☐ No	Atopic Dermatitis	☐ Yes ☐ No
High cholesterol	☐ Yes ☐ No	Psoriatic arthritis	☐ Yes ☐ No
Hypertension	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Cirrhosis	☐ Yes ☐ No	Chronic Lung Disease	☐ Yes ☐ No
Liver fibrosis	☐ Yes ☐ No	Cancers / Malignancy	☐ Yes ☐ No

If you answered YES to any of the above, please provide the dates and body area(s) of those conditions:

MEDICATIONS

CURRENT MEDICATIONS:

RECENT MEDICATIONS (12 MONTHS):

ALLERGIES

ALL ALLERGIES (DRUGS, FOOD & ENVIRONMENTAL):

SURGERIES

PHYSICIAN NAME:	PROCEDURE:	DATE (MM/YY):	BODY LOCATION:
PHYSICIAN NAME:	PROCEDURE:	DATE (MM/YY):	BODY LOCATION:
PHYSICIAN NAME:	PROCEDURE:	DATE (MM/YY):	BODY LOCATION:

Name: _____ DoB: _____

Social History

LIFE-STYLE RISK FACTORS

Alcohol Intake	☐ Never	☐ Past	☐ Present	_____ Drinks per month			
Drug Use	☐ Never	☐ Past	☐ Present	_____ Uses per month			
Smoking	☐ Never	☐ Past	☐ Present	_____ Packs per week			
Caffeine Intake	☐ Never	☐ Past	☐ Present	_____ Drinks per week			
Exercise	☐ Never	☐ Past	☐ Present	_____ Sessions per week			

Sun exposure growing up (circle one):

1	2	3	4	5	6	7
Significantly Above Avg.	Moderately Above Avg.	Slightly Above Avg.	Average	Slightly Below Avg.	Moderately Below Avg.	Significantly Below Avg.

RECREATIONAL ACTIVITIES:

FAMILY HISTORY

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

NUMBER OF CHILDREN:	AGES OF CHILDREN:

COMPLETE FAMILY MEDICAL HISTORY: