

PH: (650) 654 – 6020
FX: (650) 654 – 6025

262 REDWOOD SHORES PARKWAY
REDWOOD CITY, CA 94065

THOMAS G. MUNYON, M.D.

PATIENT REGISTRATION - CONFIDENTIAL

LAST NAME
MI

FIRST NAME

STREET ADDRESS
ZIP

CITY

STATE

DATE OF BIRTH

EMAIL ADDRESS

HOME PHONE #

CELL PHONE #

EMPLOYER

WORK PHONE #

MARITAL STATUS

SPOUSE'S OR S.O.'S NAME

PHONE

EMERGENCY CONTACT

RELATION

PHONE#

HOW DID YOU HEAR ABOUT US?

REFERRED BY

- I hereby give Munyon Dermatology Inc. Permission to send me Emails, from time to time relating to the products and services offered.
- Payment is required at the time of your visit, unless a signed financial contract is negotiated.
- Accepted methods of payment are cash, credit card (MC or VISA) or check.
- The information above is accurate and true to the best of my knowledge.

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Patient Signature

Date

HEALTH PROFILE

| | | |
|---|---|---|
| 1. ARE YOU CURRENTLY TAKING ANY MEDICATIONS OR HERBS? IF YES, PLEASE LIST: | Y | N |
| 2. ARE YOU ALLERGIC TO ANY MEDICATIONS, TO LATEX, OR TO ANY SKINCARE/ MAKEUP PRODUCTS? IF YES, PLEASE LIST: | Y | N |
| 3. ARE YOU CURRENTLY BEING TREATED FOR ANY MEDICAL CONDITION? IF YES, PLEASE LIST: | Y | N |
| 4. DO YOU HAVE ANY SKIN DISEASE, INFECTION, OR HISTORY OF SKIN CANCER IN THE AREAS TO BE TREATED? | Y | N |
| 5. DO YOU GET COLD SORES (HERPES SIMPLEX) ON YOUR FACE OR OTHER TREATMENT AREAS? | Y | N |
| 6. HAVE YOU EVER HAD A KELOID SCAR FORMATION? | Y | N |
| 7. ARE YOU PREGNANT OR BREASTFEEDING? | Y | N |
| 8. HAVE YOU EVER HAD ANY SURGERY IN THE AREA TO BE TREATED? | Y | N |
| 9. DO YOU HAVE A PACEMAKER OR INTERNAL METAL DEVICE/IMPLANT? IF YES, PLEASE LIST: | Y | N |
| 10. HAVE YOU TAKEN ACCUTANE IN THE PAST SIX MONTHS? | Y | N |
| 11. DO YOU SMOKE? IF YES, HOW OFTEN: | Y | N |
| 12. HAVE YOU HAD ANY FACIAL SURGERY, FILLER INJECTIONS, SILICONE IMPLANTS, BOTOX®, OR CHEMICAL PEELS ON YOUR FACE? IF YES, WHEN WAS YOUR MOST RECENT? | Y | N |
| 13. DO YOU REGULARLY WEAR SUNSCREEN? | Y | N |
| 14. DO YOU CURRENTLY USE SKIN CARE PRODUCTS? IF YES, PLEASE LIST: | Y | N |
| 15. DO YOU GO TO A TANNING SALON, SUNBATHE, OR USE SELF TANNER? IF YES, APPROXIMATE DATE OF LAST USE OR EXPOSURE: | Y | N |
| 16. DO YOU WAX, TWEEZE, NAIR®, OR BLEACH YOUR BODY/FACE HAIR? | Y | N |

HAVE YOU HAD ANY OF THE FOLLOWING TREATMENTS OR TAKEN ANY OF THESE MEDICATIONS WITHIN THE LAST TWO YEARS? (PLEASE CHECK ALL THAT APPLY)

- AHA OR HYDROQUINONE CHEMOTHERAPY/RADIATION MONODOX
- AMIODARONE, CORARONE, GOLD THERAPY PERMANENT MAKEUP
OR PACERONE
- ANTICOAGULANTS LASER TREATMENTS RETIN-A, DIFFEREN,
TAZORAC

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS? (CHECK ALL THAT APPLY)

- HIV/AIDS KAPOSII'S SARCOMA ROSACEA
- BLEEDING DISORDERS MENOPAUSE SEIZURES
- DIABETES MULTIPLE SCLEROSIS SHINGLES

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Another person not listed

above(name): _____

Please provide the name and address of the person who referred you so we can thank them:

Name: _____ Address: _____ Phone: (_____) _____

An article or advertisement

in: _____

Internet: _____

A seminar where I saw the doctor. The event took place

on(date): _____

at(location): _____

SCHEDULING/CANCELLATION/RETURN CHECK FEE POLICY

WE WILL MAKE EVERY EFFORT TO ACCOMMODATE YOUR SCHEDULING NEEDS. IN RETURN WE ASK THAT YOU HELP US OUT BY KEEPING SCHEDULED APPOINTMENTS AND BY NOTIFYING US IN ADVANCE IF YOU ARE UNABLE TO DO SO. WITH ADVANCE NOTICE, WE ARE OFTEN ABLE TO ACCOMMODATE OTHER PATIENTS THAT ARE WAITING TO GET AN APPOINTMENT. PLEASE READ AND SIGN OUR POLICY STATEMENT BELOW.

- IF YOU NEED TO CANCEL AN APPOINTMENT, PLEASE DO SO AT LEAST 24 HOURS IN ADVANCE
- ALL APPOINTMENTS THAT ARE CANCELLED WITH LESS THAN 24 HOURS IN ADVANCE NOTICE ARE SUBJECT TO A MISSED APPOINTMENT FEE OF \$25.00 FOR EVERY 15 MINUTES SCHEDULED.
- A \$25.00 RETURN CHECK FEE WOULD BE CHARGED TO PATIENTS IN THE EVENT OF A PERSONAL CHECK RETURNED TO MUNYON DERMATOLOGY FROM THE PATIENT'S ISSUING BANK.

I HEREBY AUTHORIZE MUNYON DERMATOLOGY TO PREPARE AND SUBMIT A CREDIT CARD CHARGE TO COVER ALL OUTSTANDING BALANCES ON MY ACCOUNT. THE FOLLOWING IS THE CREDIT CARD INFORMATION THAT I HAVE GIVEN SOLELY FOR THAT PURPOSE.

CREDIT CARD INFO: _____ - _____ - _____ - _____ EXP: _____ - _____
CVV: _____

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WE THANK YOU FOR YOUR ASSISTANCE IN COMPLYING WITH THIS POLICY AND APPRECIATE YOUR COOPERATION.

I _____ HAVE READ AND UNDERSTAND THIS POLICY.
PATIENT PRINTED NAME

PATIENT SIGNATURE

DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**I have received a copy of the Notice of Privacy Practices for
Thomas G. Munyon, M.D.**

Name of Patient

Signature of Patient or Patient Representative

Relationship to Patient

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