Samireh Z. Said, MD Inc.
13422 Newport Ave. Ste. J
Tustin, CA 92780

PATIENT INFORMATION: (Please print) Date:____/____/______

Name:____
Last First M.I.

Maiden name:____________________ Email:_________________________

Date of birth:____/____/____ Age:____ Sex:____ Marital status:__________ Spouse:___________

Mailing address:____
City State Zip

Home Phone:(_____)______________ Cell Phone:(____)__________________

Work Phone(_____)_______________ Occupation:______________________

Best number to contact: HOME CELL WORK

Who referred you to our office?____

Emergency Contact: ____
Name Phone # Relationship

Primary Care Physician:_________________________ Phone:___________________________

Preferred Pharmacy:_______________ ____
Name Address/ Cross Streets

Medical History/ Surgeries	**Medications**	**Dose/Frequency**

Allergies

Products currently using:

Facial cleanser:____________________
Sunscreen:_________________________
Body wash:________________________

Face/Body moisturizer:______________________
Shampoo/Conditioner:_______________________
Detergent/Fabric softener:___________________

SAMIREH SAID, M.D., INC.
Diplomat American board of Dermatology
American Society of Dermatologic Surgery
American College of Mohs Surgery
13422 Newport Ave., Ste J
Tustin, CA 92780

Name:______________________________ Date:________________

DOB:____________________ Sex: M F

Past Medical History (check all that apply)

- ☐Anxiety
- ☐Arthritis
- ☐Asthma
- ☐Atrial Fibrillation
- ☐Bone marrow transplantation
- ☐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
- ☐Leukemia
- ☐Lung Cancer
- ☐Lymphoma
- ☐Prostate cancer
- ☐Radiation treatment
- ☐Seizures
- ☐Stroke

Other: ____________________
____
____
____

Past Surgical History (check all that apply)

- ☐Appendix (appendectomy)
- ☐Bladder (cystectomy)
- ☐Breast: Breast biopsy
- ☐Breast: Lumpectomy: Both Right Left
- ☐Breast: Mastectomy: Both Right Left
- ☐Colon: (colectomy)
- ☐Colon: Colostomy
- ☐Gallbladder (Cholecystectomy)
- ☐Heart: Heart transplant
- ☐Heart: Coronary artery bypass surgery
- ☐Joint replacement: Hip Both Right Left
- ☐Joint replacement: Knee Both Right Left
- ☐Kidney: Kidney biopsy
- ☐Kidney: Stone removal
- ☐Kidney: Kidney transplant
- ☐Liver: Liver transplant
- ☐Liver: Shunt
- ☐Ovaries (Oophorectomy)
- ☐Ovaries: Endometriosis
- ☐Ovaries: Ovarian cancer
- ☐Ovaries: Ovarian cyst
- ☐Ovaries: Tubal ligation
- ☐Pancreas: Pancreatectomy
- ☐Prostate: Prostate biopsy
- ☐Prostate: Prostate cancer
- ☐Rectum: Low anterior resection
- ☐Skin: Basal cell carcinoma
- ☐Skin: Melanoma
- ☐Skin: Skin Biopsy
- ☐Skin: Squamous cell carcinoma
- ☐Spleen (splenectomy)
- ☐Testicles (orchiectomy)
- ☐Uterus (hysterectomy)
- ☐Uterus: uterine cancer
- ☐Uterus: cervical cancer

Other:____________________

Medications:

________________ ________________ ________________
________________ ________________ ________________
________________ ________________ ________________

Allergies : Y None

____

Allergies to : Adhesive Y N
Lidocaine Y N

Smoking History: (check one)

- ☐Never smoker
- ☐Current some day smoker
- ☐Every day smoker

Preferred Language: ____________

Race/ Ethnicity: (check one)

- ☐Unspecified
- ☐White
- ☐Asian
- ☐African American
- Other: ____________

Ethnic Group:

- ☐Unspecified
- ☐Hispanic or Latino
- ☐Not Hispanic or Latino
- ☐Unknown

Skin Disease History: (check all that apply)

- ☐Acne
- ☐Actinic Keratoses
- ☐Asthma
- ☐Basal cell carcinoma
- ☐Blistering sunburns
- ☐Dry skin
- ☐Eczema
- ☐Flaking or itching scalp
- ☐Hay fever/ Allergies
- ☐Melanoma
- ☐Poison Ivy
- ☐Precancerous moles
- ☐Psoriasis
- ☐Squamous cell carcinoma
- Other: ____________

Do you wear sunscreen? Y N SPF: ______
Do you tan in a tanning salon? Y N
Do you have family history of Melanoma? Y N if yes, who? ____________

What product(s) do you use for your skincare routine?

____
____
____

PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name: ______________________________ Date of Birth: ___/___/______
(Please Print LAST, FIRST)

RELEASE OF INFORMATION:

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

☒ Patient or Responsible Party Signature ______________________________ Date ___/___/___

PAYMENT POLICY:

Medicare: We are participating providers of the Medicare program. Patients are responsible for meeting their annual $110.00 deductible and paying for the 20% co-payment. We do file with secondary /supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed. If you have Medi-cal or a HMO as a secondary, the balance after Medicare pays is your responsibility.

Note: If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you that you will be a cash patient.

PPO or other managed care patients: You will be responsible for paying your annual deductible, copayment, coinsurance and charges for any non-covered, cosmetic services.

MEDI-CAL & HMO's: Dr. Said will not accept any kind of an HMO or Medi-cal insurance as a primary or secondary plan. You will be considered a cash patient and the entire balance is due at the time of service or after your primary insurance has paid.

Commercial Patients: Patients who are covered by private, commercial plans in which the physician they are seeing is not a provider will be required to pay 35% of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

☒ Patient or Responsible Party Signature ______________________________ Date ___/___/___

MEDICARE PATIENTS ONLY:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

☒ Signature as it appears on Medicare Card ______________________________ Date ___/___/___

Samireh Z. Said, M.D., Inc.

Patient Name: ______________________________ Date of Birth: ___/___/______
(Please Print LAST, FIRST)

AUTHORIZATION TO LEAVE MESSAGES

I give my permission for the staff of Dr. Said's office to leave messages on my telephone answering machine regarding my health care, test results, or my appointments.

☐Patient or Guardian Signature: ______________________ Date: ___/___/______

CONSENT TO MEDICAL CARE & TREATMENT OF MINOR CHILDREN

I, ______, the natural parent/legal guardian

(LAST, FIRST NAME)

of ______, ______________________________

(PATIENT'S NAME LAST, FIRST) (PATIENT'S DATE OF BIRTH)

authorize and consent to medical and surgical care, treatment and procedures to be performed for my child by a licensed physician/provider. In the sole discretion of the attending physician/provider, such care, treatment and procedures are necessary or advisable in the interest of my child's health and well-being. This consent is valid until I have notified Dr. Said's office that this policy has been revoked.

☐______________________________ ______________

SIGNATURE OF PARENT/GUARDIAN DATE

PATIENTS RESPONSIBILITY FOR CALLING RE. LABORATORY RESULTS

Dr. Said feels it is very important that you receive all laboratory results including blood work, cultures and pathology results. It is standard procedure for our office to notify our patients by either phone or mail of their results. However, in the unlikely event that a laboratory result is not received by our office, standard procedures for notification of our patients may not take place. We therefore ask our patients to share in the responsibility of obtaining their laboratory results by calling for results if not notified after a reasonable time period, i.e., three to four weeks for biopsy results, seven days for culture results and two weeks for routine blood work. Your physician or nurse will let you know during your visit what test will be done so you are aware of what results are pending. Your health care is our number one priority. Thank you for partnering with us in your care.

PLEASE NOTE: If a biopsy is done today a separate bill from the pathologist office will be sent to you.

Sincerely,

Samireh Z. Said, M.D.

I will take responsibility for calling for my laboratory results if not notified in a reasonable amount of time

☒Patient or Guardian Signature: ______________________ Date: ___/___/______