RALPH A. MASSEY, M.D., F.A.A.D.

DERMATOLOGIC, COSMETIC & MOHS MICROGRAPHIC SURGERY

1260 15th STREET, SUITE 1401
SANTA MONICA, CA 90404

TELEPHONE (310) 434-2495
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Last Name:_____ First name:_____Middle Initial:____

Address: _____

_____

Date of Birth: _____ / _____ / _____ **Social Security #**: _____

Home Tel #: _____ **Work** Tel #: _____

Cell Tel #: _____ **Email**: _____

Primary Care Physician (PCP):

Name: _____ Tel #: _____

Referring / Other Physician:

Name: _____ Tel #: _____

Name: _____ Tel #: _____

INSURANCE INFORMATION

MEDICARE: ☐ **PPO:** ☐ **POS:** ☐ **HMO:** ☐

MEDICAID: ☐ **NONE / SELF PAY:** ☐ **OTHER:** _____

Please show your insurance cards to the front desk OR fill out your insurance information below:

Primary Insurance:

Policy #: _____

Group #: _____

Carrier (eg Medicare , Anthem, Blue Cross etc): _____

Secondary Insurance:

Policy #: _____

Group #: _____

Carrier (eg Medicare , Anthem, Blue Cross etc): _____

I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO RALPH MASSEY MD. I AM FINACIALLY RESPONSIBLE FOR ANY COPAY, DEDUCTABLE AND / OR ANY NON-COVERED SERVICES.

Signature: _____

Name: _____

Date: _____/_____/ _____

PAST MEDICAL HISTORY

Do you have a history of prior skin cancers?

NO ☐ **YES** ☐ **If YES please indicate what type of skin cancer:**

Uncertain of type ☐
Basal Cell Cancer (BCC) ☐
Squamous cell Cancer (SCC) ☐
Melanoma ☐
Other: _____

Do you have a history of other (none skin related) malignancy (cancer)?

NO ☐ **YES** ☐ **If YES please indicate what type of cancer:**

Lymphoma ☐
Leukemia ☐
Lung Cancer ☐
Breast Cancer ☐
Prostate Cancer ☐
Colon / Bowel Cancer ☐
Pancreatic Cancer ☐
Brain Cancer ☐
Other: _____

Do you have a history of Cardiovascular Disease (Heart Disease)?

NO ☐ **YES** ☐ **If YES please indicate what type:**

Hypertension (HTN): (High Blood Pressure) ☐
Myocardial Infarct(MI): (Heart Attack) ☐
Heart Valve Disease: ☐
Heart Valve Replacement: ☐
Pacemaker: ☐
Other: _____

Do you have a history of Lung Disease?

NO ☐ **YES** ☐ **If YES please indicate what type:**

Asthma: ☐

Emphysema: ☐

Chronic Bronchitis: ☐

Other: _____

Do you have a history of Inflammatory Bowel Disease?

NO ☐ **YES** ☐ **If YES please indicate what type:**

Crohn's Disease: ☐

Ulcerative Colitis: ☐

Do you have a history of major Infectious Disease?

NO ☐ **YES** ☐ **If YES please indicate what type:**

Tuberculosis (TB): ☐

Hepatitis B or C: ☐

HIV / AIDS: ☐

Other: _____

Do you have a history of Endocrine Disease?

NO ☐ **YES** ☐ **If YES please indicate what type:**

Diabetes: ☐

Thyroid Disease: ☐

Other: _____

Do you have a history of Keloids?

NO ☐ **YES** ☐

PAST SURGICAL HISTORY

Do you have a history of significant / major surgery?

NO ☐ **If NO go to next question.** **YES** ☐ **If YES please indicate what type:**

HEART SURGERY

Cardiac Bypass Surgery: ☐

Cardiac Stents: ☐

Heart Valve Replacement: ☐ **Other:** _____

BOWEL SURGERY

Appendectomy: ☐

Gall Bladder Removal: ☐

Bowel Resection: ☐

Gastric Bypass Surgery: ☐ **Other:** _____

ORTHOPEDIC SURGERY

Hip replacement: ☐

Knee Replacement: ☐

Spine Surgery: ☐ **Other:** _____

TRANSPLANT SURGERY

Renal (Kidney) Transplant: ☐

Heart Transplant: ☐

Lung Transplant: ☐

Liver Transplant: ☐

Bone Marrow Transplant: ☐ **Other:** _____

COSMETIC SURGERY

Face Lift: ☐

Eyelid Lift: ☐

Forehead Lift: ☐

Liposuction: ☐

Tummy-Tuck: (Abdominoplasty) ☐ **Other:** _____

CHEMOTHERAPY & RADIATION THERAPY

Do you have a history of Chemotherapy ?

NO ☐ **YES** ☐

Do you have a history of Radiation Therapy ?

NO ☐ **YES** ☐ **If YES please indicate for what:**

Radiation for Cancer: ☐ **Brain** ☐ **Breast** ☐ **Thyroid** ☐ **Prostate** ☐ **Other**_____

Radiation for Acne: ☐ **Face** ☐ **Trunk**

Radiation for Other: _____

Do you have a history of Ultra-Violet Light Therapy (eg. PUVA / UVB treatments?)

NO ☐ **YES** ☐ **If YES please indicate what type:**

Medical PUVA / UVB Rx (eg for psoriasis / eczema): ☐

Indoor U.V. Tanning (More than 10 sessions): ☐

MEDICATIONS

Are you are <u>currently</u> taking any medications?

NO ☐ **YES** ☐ **If YES please indicate which medication:**

Aspirin: ☐
Plavix: ☐
Coumadin: ☐
Other: _____

_____

_____

_____

Do you have a history of ALLERGY to any Medications?

NO ☐ **YES** ☐ **If YES please indicate which medication:**

Penicillin: ☐
Sulfa: ☐
Iodine: ☐
Codeine: ☐
Vicodine: ☐ **Other:** _____

YOUR PREFFERED PHARMACY

Pharmacy Name & Address: _____

_____

Pharmacy Tel #: _____ **Pharmacy ZIP code**: _____

SOCIAL & FAMILY HISTORY

Sex: ☐ Male ☐ Female ☐ Other

Race: ☐ White ☐ Asian ☐ Hispanic ☐ Black ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Divorced

Do you have a history of major illness in your *immediate* Family:

NO ☐ **YES** ☐ **If YES please specify which illness and which relative:**

Melanoma: ☐ _____

Pancreatic Cancer: ☐ _____

Other: _____

Do you Smoke?

NO ☐ **YES** ☐

Do you Drink Alcohol?

NO ☐ **YES** ☐

What is your Occupation?

Retired: ☐

Student: ☐

Unemployed: ☐

Other: _____

What are your Hobbies?

_____

REVIEW OF SYSTEMS

Do you presently have any *symptoms* from any of the following?

NO ☐ **YES** ☐ **If YES please detail:**

General Health? _____

Eyes / Vision ? _____

Ear / Nose / Throat / Mouth ? _____

Heart ? _____

Lungs / Breathing ? _____

Stomach / Bowels ? _____

Kidneys / Bladder ? _____

Muscles / Joints? _____

Diabetes / Thyroid problems? _____

Headaches / Seizures? _____

Psychiatric disorder ? _____

Allergic / Immunology disorders? _____

Blood / Bleeding disorders ? _____

Anesthesia problems ? _____

RALPH A. MASSEY, MD INC.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Ralph A. Massey, MD Inc. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Ralph A. Massey, MD Inc 's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.
Ralph A. Massey, MD Inc reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Ralph A. Massey, MD Inc Privacy Officer at [*1260 15th Street, #1401,Santa Monica, CA 90404*].

I give my consent such that the Ralph A. Massey, MD Inc may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

I give my consent such that the Ralph A. Massey, MD Inc may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I give my consent such that the Ralph A. Massey, MD Inc may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that the Ralph A. Massey, MD Inc restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the Ralph A. Massey, MD Inc's use and disclosure of my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO).

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Ralph A. Massey, MD Inc may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Name of Patient or Legal Guardian Date

Designation for Release of Medical Information to a Family Member, Friend or Legal Representative

Introduction

The Health Portability and Accountability act (HIPAA) allows physicians to use their professional judgment on disclosing certain personal health information to family, friends, etc. without an authorization. This form is an aid to the physicians in making a determination on disclosing such information. Cosmetic Surgery Center of Santa Monica and Dr Ralph Massey realizes that there are times when you, the patient, may want another person to be knowledgeable about your medical condition or medial needs. We want you to be able, if you so desire, to name a person to whom you want the office staff to speak with about your medical condition. To enable that, we would ask that you complete the form listed below. Please note: This designation is valid until you cancel it in writing.

DESIGNATION STATEMENT

I designate the following person(s) to be able to speak to a physician at Cosmetic Surgery of Santa Monica, or other staff member, should it be necessary, on my behalf. I hereby give permission to Dr Ralph Massey, CSCSM and staff to release to my designee(s) any information about my medical condition or medical needs or the status of my account and I release CSCSM its physicians, and staff, from any claim of confidentiality in connections with the release of this information.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

OR

☐ I DECLINE TO DESIGNATE ANYONE

Patient's Name: _____ Patient's Signature: _____

Date: _____