



**Dr. T. Anthony Hoang-Xuan, FAAD**  
**Board-Certified Dermatologist**  
**Medical • Surgical • Cosmetic • Laser**



**W**elcome to **Pacific Coast Dermatology**. It is our pleasure to serve you in a setting staffed with the leading professionals in the field. Our staffs are committed to assisting you in every way possible, in keeping with the latest state of the art care.

Enclosed you will find our standard forms that need to be filled out prior to being seen. By filling them out before you come in for your appointment you will save both yourself and us a great deal of time. Filling out the forms in advance will allow us to spend the maximum time in actual consultation with you. If you cannot have the forms filled out before you arrive for your appointment, please come in 15 minutes early so that you can complete them before you are seen.

Also, please be sure to bring your insurance card, identification, and any secondary insurance you may have. We accept most PPO insurance plans and Medicare. It is YOUR responsibility to know your co-pays and deductibles, and how your insurance will cover your visits if we are not a preferred provider.

We are setting aside a specific time in our day to serve you; please have the courtesy to advise us with at least 24 hours notice that you are unable to keep your appointment. It has unfortunately become necessary to impose a \$50.00 charge for not showing up for an appointment and not notifying us in advance. This fee will apply to the 2nd failure to keep your appointment and for future "No Shows".

Please note that unless you are required to take aspirin, it is best to avoid taking it for three days prior to your appointment if you are having a biopsy, excision or injection. Also try to avoid taking any anti-inflammatory such as ibuprofen (Motrin, Advil & Aleve) or alcohol.

We look forward to serving you!

Regards,

Dr. T. Anthony Hoang, FAAD



13768 Roswell Ave, Suite 102  
 Chino, CA 91710  
 Phone (909) 364-1959  
 Fax (909) 752-4171  
 www.PacificCoastDerm.com

## PATIENT REGISTRATION

Mr.  Mrs.  Miss  Ms.  Dr.

Patient \_\_\_\_\_ Today's Date \_\_\_\_\_  
Last Name First Name MI

Address \_\_\_\_\_  
Street City State Zip

Birthdate \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ Social Security # \_\_\_\_\_

Marital Status  Single  Married  Widowed  Divorced Primary Language Spoken \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

**If Student:**  Full Time  Part Time Name of School: \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Patient's Occupation \_\_\_\_\_

**In case of an emergency, whom can we contact?**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

City & State of Referring Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_

**Mailing address** (if different from above)

\_\_\_\_\_  
Street City State Zip

**PERSON RESPONSIBLE FOR PAYMENT** (if different from patient & **required for minor patient**)

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Last Name First Name MI

Address \_\_\_\_\_  
Street City State Zip

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Birthdate \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_\_\_ Sex  Male  Female

**Do we have your permission to:**

Email you (non-medical) info, events and specials?  YES  NO If yes, Email: \_\_\_\_\_

Leave a message on your answering machine at home?  YES  NO

Leave a message at your place of employment?  YES  NO

Discuss your medical condition with any member of your household?  YES  NO

If yes, whom: \_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_  
 Patient Signature Date



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## INSURANCE INFORMATION

**Please present insurance card at the time of check in. ALL CHARGES ARE DUE AT TIME OF SERVICE.**

Primary Insurance Name	Secondary Insurance Name
Name of Insured	Name of Insured
Ins. Address	Ins. Address
DOB of Insured	DOB of Insured
Insured ID #	Insured ID #
Group #	Group #
Employer Name	Employer Name
Employer Address	Employer Address
Employer Phone	Employer Phone
Relationship to Insured	Relationship to Insured

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 authorize Pacific Coast Dermatology to release to the Social Security Administration and Center for Medicare Service, 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 on my behalf to Pacific Coast Dermatology (Dr. T. Anthony Hoang-Xuan, FAAD) for any services furnished to me by this office. Regulations pertaining to Medicare of benefits apply. This authorization is valid until revoked in writing. If I do not sign this consent, or later revoke it, Dr. Hoang-Xuan my decline to provide treatment to me.

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the release of any information needed to act upon this request that payment of authorized benefits be made on my behalf. I assign payment for the unpaid charges to the physician for his services. I understand I am fully responsible for any remaining balances. I also understand that if my insurance requires a written referral or pre-authorization from my primary care physician, I am responsible to ensure that one is provided before the visit occurs (even if this office schedules an appointment with Dr. Hoang for me) or I will be liable for the full charges incurred.

Pacific Coast Dermatology/Dr. Hoang-Xuan DOES NOT PARTICIPATE with any of the Medicare HMO plans.

Pacific Coast Dermatology/Dr. Hoang-Xuan DOES NOT fill out any worker's compensation paperwork. I am responsible for full payment for services rendered by Dr. Hoang-Xuan even if my skin condition is work-related.

If I have Medigap coverage, I request authorized Medigap benefits to be made on my behalf to Pacific Coast Dermatology (Dr. T. Anthony Hoang-Xuan, FAAD) for any services furnished to me. I authorize Pacific Coast Dermatology to release to my Medigap carrier any information needed to determine these benefits for the benefits payable to related services.

\_\_\_\_\_  
 Signature of patient/policy holder/legal guardian

\_\_\_\_\_  
 Print Name & Relationship to patient (if not patient)

\_\_\_\_\_  
 Date



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## MEDICAL HISTORY

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

**Please note that insurance companies and Medicare consider the removal of benign growths NOT medically necessary and DO NOT reimburse these procedures.**

**Do you have or have had any of the following? (if yes, please check)**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Acne  | <input type="checkbox"/> Diabetes                         | <input type="checkbox"/> Multiple Sclerosis        |
| <input type="checkbox"/> Actinic Keratosis                                   | <input type="checkbox"/> Depression                       | <input type="checkbox"/> Melanoma                  |
| <input type="checkbox"/> Artificial heart valve                              | <input type="checkbox"/> Down's Syndrome                  | <input type="checkbox"/> Pacemaker/ Defibrillator  |
| <input type="checkbox"/> Artificial Joints or Metal Implant                  | <input type="checkbox"/> Migraines                        | <input type="checkbox"/> Psoriasis                 |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Epilepsy/Seizures                | <input type="checkbox"/> Seasonal allergies        |
| <input type="checkbox"/> Atopic Dermatitis                                   | <input type="checkbox"/> Heartburn/Ulcer/Gastritis/Reflux | <input type="checkbox"/> Skin Cancer (BCC or SCC)  |
| <input type="checkbox"/> Atrial Fibrillation                                 | <input type="checkbox"/> Heart disease                    | <input type="checkbox"/> Thyroid trouble           |
| <input type="checkbox"/> Autoimmune disease<br>(Lupus, Rheumatoid Arthritis) | <input type="checkbox"/> Hepatitis/ Jaundice              | <input type="checkbox"/> Cancer (what type? _____) |
| <input type="checkbox"/> Bleeding disorder / Blood Clots                     | <input type="checkbox"/> High Blood Pressure              | <input type="checkbox"/> Other conditions          |
| <input type="checkbox"/> Chronic Fatigue/ Fibromyalgia                       | <input type="checkbox"/> HIV                              | Please list: _____                                 |
| <input type="checkbox"/> Cold Sores/ Herpes                                  | <input type="checkbox"/> Keloids or Abnormal Scarring     | _____  |
|  | <input type="checkbox"/> Kidney / Liver / Lung disease(s) | _____  |

**Please list any medications you are currently taking:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please list major surgeries:**

\_\_\_\_\_ Date: \_\_\_\_\_

**Please list major hospitalizations:**

\_\_\_\_\_ Date: \_\_\_\_\_

**ALLERGIES**

**Any medications?**  No  Yes (Please list) \_\_\_\_\_

**Tape or bandages?**  No  Yes

**Numbing medications or dental anesthesia?**  No  Yes

**Please list any other allergies** \_\_\_\_\_

**ALLERGIES**

**Have you had any of the following? (please check all that apply)**

- |  |   |                                       |   |   |
|--|---|---------------------------------------|---|---|
| <input type="checkbox"/> Weight change       | <input type="checkbox"/> Neck stiffness             | <input type="checkbox"/> Nausea       | <input type="checkbox"/> Change in hair pattern | <input type="checkbox"/> Headache       |
| <input type="checkbox"/> Fever               | <input type="checkbox"/> Enlarged glands            | <input type="checkbox"/> Vomiting     | <input type="checkbox"/> Easy bruising          | <input type="checkbox"/> Vision change  |
| <input type="checkbox"/> Chills              | <input type="checkbox"/> Sore throat                | <input type="checkbox"/> Diarrhea     | <input type="checkbox"/> Abnormal bleeding      | <input type="checkbox"/> Ringing in ear |
| <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Chest pain                 | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fainting               | <input type="checkbox"/> Palpitation    |
| <input type="checkbox"/> Blood in urine      | <input type="checkbox"/> Seizures                   | <input type="checkbox"/> Leg swelling | <input type="checkbox"/> Joint pain             | <input type="checkbox"/> Muscle ache    |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Irregular menstrual cycles | <input type="checkbox"/> Depression   | <input type="checkbox"/> Recurrent nosebleeds   | <input type="checkbox"/> Cough          |
| <input type="checkbox"/> Nervousness         | <input type="checkbox"/> Heat/Cold intolerance      |                                       |   |   |



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## MEDICAL HISTORY

**Please list any relatives that have had any of the following conditions?** (father, mother, grandfather, grandmother, brother, sister)

- |  |  |
|--|--|
| <input type="checkbox"/> Skin Cancer: _____          | <input type="checkbox"/> Seasonal Allergies: _____ |
| <input type="checkbox"/> Eczema: _____               | <input type="checkbox"/> Psoriasis: _____          |
| <input type="checkbox"/> Melanoma : _____            | <input type="checkbox"/> Autoimmune disease: _____ |
| <input type="checkbox"/> Diabetes: _____             | <input type="checkbox"/> Cancer: _____             |
| <input type="checkbox"/> Elevated Cholesterol: _____ | <input type="checkbox"/> Other: _____              |

**How many of the following do you have?** Brothers: \_\_\_\_\_ Sisters: \_\_\_\_\_ Sons: \_\_\_\_\_ Daughters: \_\_\_\_\_

Do you develop skin rashes in reaction to Medication Food Environment? Please explain \_\_\_\_\_

When you are exposed to sun, do you: Tan only Tan & Burn Burn

Do you regularly use sun screen  Yes  No

Do you take Coumadin or other blood thinners?  Yes  No

Do you take Aspirin daily?  Yes  No

**Are you pregnant or nursing?**  Yes  No

Do you smoke?  Yes  No

Do you exercise?  Yes  No

Do you drink alcoholic beverages ?  Yes  No

Do you drink more than 20 alcoholic beverages/wk?  Yes  No

What is your occupation? \_\_\_\_\_ What are your hobbies? \_\_\_\_\_

**I certify that this history form is filled out completely and accurately. I have answered all questions truthfully and to the best of my knowledge.**

\_\_\_\_\_  
**Patient's or Guardian's Signature** **Date**

\_\_\_\_\_  
**Physician's Signature** **Date**

### HOW DID YOU HEAR ABOUT US?

We would appreciate your response in following section.

Physician (Dr. \_\_\_\_\_)  Family or Friend (name: \_\_\_\_\_)

Insurance Website/Book  Verizon Yellow Pages  Chino Yellow Book  Internet Search

Other: \_\_\_\_\_

### HEALTH ISSUES THAT INTEREST YOU

Please check all that apply:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Botox Cosmetic Therapy | <input type="checkbox"/> Acne / Acne Scars    | <input type="checkbox"/> Spider Veins Treatments      |
| <input type="checkbox"/> Facial Fillers         | <input type="checkbox"/> Skin Care            | <input type="checkbox"/> Plumping the Lips            |
| <input type="checkbox"/> Skin Rejuvenation      | <input type="checkbox"/> Laser Treatments     | <input type="checkbox"/> Laser Resurfacing            |
| <input type="checkbox"/> Sunscreen              | <input type="checkbox"/> Reducing Wrinkles    | <input type="checkbox"/> Liver / Age Spots            |
| <input type="checkbox"/> Chemical Peels         | <input type="checkbox"/> Eyelash Conditioning | <input type="checkbox"/> Other, please specify: _____ |



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## FINANCIAL POLICY

Thank you for choosing Pacific Coast Dermatology as your dermatology provider. We are committed to your treatment being a successful. Our Insurance Department and Patient Finance Counselor will work very hard to make sure your paperwork is filed accurately and promptly.

In order to provide you with the highest quality service while keeping our billing costs low, we offer EASY-PAY. We simply maintain your credit/debit on file to satisfy all co-pays, deductibles, and balances not covered by your insurance. We will continue sending paper statement to you and balance is due upon receipt. If you wish to send in a check, please call our office within ten days of receiving our statement. Otherwise, the balance due will be charged on the credit card on file. Our Patient Finance Counselor will be more than happy to give you more information about EASY-PAY.

We accept VISA, MASTERCARD, DISCOVER, DEBIT CARD, and CASH.

### TREATMENT CONSENT FOR UNACCOMPANIED MINOR PATIENT (under 18 years of age):

I state that I am the legal guardian of this patient. I authorized Dr. Hoang-Xuan and/or medical staffs under his discretion to render medical care even if I cannot be present. I also understand that I will be responsible to pay any bills that are incurred as a result of the visits.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

### INSURANCE AND INSURANCE COLLECTION:

Please understand that insurance reimbursement can be a long and difficult process for our office. In fact, insurers will routinely stall, deny, and reduce payments. To that end, our billing staff has undergone extensive and rigorous training to maximize your insurance reimbursement, while reducing the time by which they pay. Please **initial** next to your category of insurance listed below, as this will help us speed up payment and eliminate any confusion in the future. Thank you.

#### Plans in which we are a participate providers:

**Aetna, Blue Cross, Blue Shield, First Health, Great West, Health Net, TriCare, and United Health Care/PacifiCare**

\_\_\_\_ **PPO PLANS.** We have agreed to accept the discounted rate from your plan; however, all co-insurance, copay, and deductible are your responsibility. We will estimate balances to the best of our ability. Since the balances are estimates only, we recommend EASY-PAY. After your insurance has cleared, you may leave the balance on your card or you can send a check. Please indicate your preference.

\_\_\_\_\_ Transfer my balance

\_\_\_\_\_ Call first, I might want to send a check

#### Medicare:

\_\_\_\_\_ As a participating provider, we may bill your Medicare carrier. You are responsible for your 20% co-payment and annual deductible and we must collect it each and every visit. If you prefer, we can bill your co-pays to your EASY-PAY account on a weekly, biweekly, or monthly basis.

#### Secondary Insurers:

\_\_\_\_\_ Having more than one insurer DOES NOT necessarily means that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. We may bill your secondary carrier as a courtesy. You are responsible for any balances after your insurance(s) has cleared.

#### Non-Contracted or Indemnity Insurance Plans:

\_\_\_\_\_ We may bill your insurance as a courtesy. Our office, as a convenience and a service to you, will absorb all costs incurred for billing. However, we require that you pre-authorize the "letter for insurance stalls" in order to expedite your insurance payment. If you are a new patient, we may require that you enroll in EASY-PAY to guarantee your account. In the event that your insurance does not reimburse us within 45 days, we will simply transfer the balance of your account to your credit, debit card. Please indicate your preference.

\_\_\_\_\_ Transfer my balance

\_\_\_\_\_ Call first, I might want to send a check

