Peter Helton, D.O.
1901 Westcliff Dr. Suite #2, Newport Beach, CA 92660
(949) 646-3376

PATIENT REGISTRATION FORM
(PLEASE PRINT CLEARLY AND FILL OUT COMPLETELY)

Patient's Name:_____ SSN:_____

Street:_____ Date of Birth:_____ Age_____

City:_____State/Zip_____Home Phone:_____
Billing Address if different than above: Cell Phone: _____
Street:_____

City:_____State/Zip_____HomePhone:_____
Marital Status: M S D W Referred By:_____
Sex: M F Emergency Contact:_____ Phone Number:_____

Responsible Party:_____ SSN:_____

Street:_____ Date of Birth:_____ Age_____

City:_____State/Zip_____HomePhone:_____

Employer:_____ Work Phone:_____
Preferred Pharmacy Name & Location:_____.
Please give us your e-mail address if you would be interested in receiving our specials by e-mail: _____
Can confidential messages be left on your answering machine or voicemail? Y N
Please list, if any, person(s) whom we may inform about your general medical condition, your diagnosis, and/or your payment operations:
Name:_____ Phone Number:_____
Name:_____ Phone Number:_____

PRIMARY INSURANCE	SECONDARY INSURANCE
Name:_____	**Name:**_____
Insurance Type: _____	**Insurance Type:** _____
Primary Name:_____	**Primary Name:**_____
Primary DOB:_____	**Primary DOB:**_____

Assignment of Benefits:
I assign all insurance benefits to **Dr. Peter Helton**. I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that Dr. Helton's office is **not responsible to know my plan, what it will pay for or the deductible requirements**. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I hereby give my consent for examination, treatment and insurance billing.

Permission for Photography:
I hereby give permission to *Helton Skin and Laser Institute* to take necessary clinical photographs of me with the understanding that such photographs are for confidential, clinical record purposes and that all photographs remain the property of the doctor.

Internet Publishing:
I agree not to post electronic information about the doctor or *Helton Skin & Laser Institute* without the Doctor's written permission

Acknowledgment of Receipt of Notice of Privacy Practices:
I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Open Payments Database:
The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov

Signature:_____**Date:**_____
Patient/Responsible Party

Print Name:_____

If not signed by the patient, please indicate:

Relationship:_____

Name of Patient:_____

Dermatology Medical History

Patient:_____ Date:_____
Reason for today's visit:_____
Are you allergic to any medications? ☐YES ☐NO If yes, list: _____
_____
Have you ever had a reaction to dental anesthesia (Lidocaine)? ☐YES ☐NO
List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins and
herbals):_____
_____
Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	**YES**	**NO**	**Other Systemic:**	**YES**	**NO**
Bronchitis:	☐	☐	Diabetes	☐	☐
Emphysema	☐	☐	Excessive thirst/hunger	☐	☐
Asthma	☐	☐	Thyroid	☐	☐
Shortness of breath	☐	☐	Kidney	☐	☐
Cardiovascular:	**YES**	**NO**	Bladder	☐	☐
Pacemaker `	☐	☐	Artificial joint	☐	☐
Inflammation of vein	☐	☐	Arthritis/joint deformity	☐	☐
High blood pressure	☐	☐	Nausea, vomiting, diarrhea		
Chest pain	☐	☐	when taking antibiotics	☐	☐
Heart attack	☐	☐	Convulsions, epilepsy		
Blood clots	☐	☐	seizures	☐	☐
Heart murmur	☐	☐			
Irregular heartbeat	☐	☐			

Skin:
When you are exposed to sun do you: ☐Tan only ☐Tan and burn ☐Burn
Have you ever had skin cancer: ☐YES ☐NO If yes, what kind?_____
_____
Do you have a history or any specific skin diseases? ☐YES ☐NO If yes, please list:_____
_____
Do you develop skin reactions to: ☐Medications ☐Food ☐Environment If yes, please explain:__
_____
List any other diseases or conditions:_____
List surgical procedures you have had in the last 6 months:_____
_____

Social History:
Do you drink alcohol? ☐YES ☐NO If yes, _____ drinks per day
Have you used IV drugs? ☐YES ☐NO
Do you smoke? ☐YES ☐NO If yes, how much?_____
Have you been exposed to HIV (AIDS)? ☐YES ☐NO

Please answer the following questions:
Do you bleed easily? ☐YES ☐NO
(Women) Are you pregnant? ☐YES ☐NO If yes, when is your due date?_____
What is your occupation?_____
What are your hobbies?_____
_____
Is there anything else you would like the Doctor to know?_____
_____

Helton Skin and Laser Institute

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949-646-3376 - office 949-646-3303 – fax

No Refund Policy

We do not offer refunds on any services rendered. Aesthetic results vary from person to person. While we do our best to achieve desired outcomes, results cannot be guaranteed. Clients are responsible for any additional treatments needed to achieve desired outcomes.

Additionally, we do not offer refunds on **prepaid services** or refunds to deposits made on services. Funds can be reallocated to an **office credit** that can be used towards the purchase of the different services offered at Helton Skin & Laser Institute.

Due to sanitary reasons, we are unable to offer refunds or exchanges on all products. All sales are final.

There are no refunds on Gift cards. Gift cards must be presented at the time of purchase.

Signature: _____ _____
Patient/Responsible Party Date

Print Name: _____

If not signed by the patient, please indicate:

Relationship: _____

Name of Patient: _____