Dermatology
Surgery
Medical Group

Dale A. Kooistra, M.D., Ph.D.
www.drdalekooistra.com

15525 Pomerado Road • Suite D-2 • Poway, CA 92064 • (858) 675-8001 • Fax (858) 487-1337

Dear _____,

Welcome to our office.

Your appointment is _____ at _____.

Please complete the enclosed packet and bring it to your appointment, along with a photo I.D. ***Please do not mail in the forms.***

We will need to make a copy of your insurance card(s) and collect a co-payment, if applicable. Co-payments are due at the time of your appointment. **Unfortunately, if you do not bring your insurance card(s) with you to the appointment, we will be unable to provide you service.**

The office is located at 15525 Pomerado Road, Suite D-2, in the Pomerado Medical Dental Complex on the south side of the building. Driving directions are included on the next page.

Office hours are: Monday, Wednesday and Friday: 8:00 A.M. to 5:00 P.M.
Tuesday (alternating): 8:00 A.M. to 1:00 P.M. / 8:00 A.M. to 5:00 P.M.
Thursday: 8:00 A.M. to 1:00 P.M.

Information you might find helpful:
Prescription Refills: For refills of medication prescribed by Dr. Kooistra, please have your pharmacy fax our office at (858) 487-1337. Please allow a minimum of 24 hours for refills to be approved.

Biopsy and Laboratory Results: It takes 10-14 days to receive biopsy results. Once we receive them, a nurse will call to notify you of the results. These tests are performed by an outside laboratory, which may bill you or your insurance company directly for their services.

Billing: Billing is done by an offsite service. For questions related to your account with our office, please call our billing manager, Debbie, at (858) 449-7646. ***All cosmetic and "elective" procedures must be paid for at the time of your visit.*** We accept all credit cards except American Express.

We would appreciate a 24-hour cancellation notice so we can accommodate other patients with an earlier appointment.

The above information will help us to make your appointment at our office more efficient.

Thank you for your cooperation.

Directions to Our Office

15525 Pomerado Rd., D-2
Poway, CA 92064

Our office complex is at the corner of Pomerado Rd. and Monte Vista Rd., about two blocks south of Pomerado Hospital.

Coming from I-15 Southbound:
Take the Rancho Bernardo Rd. exit
Turn left (east) onto Rancho Bernardo Rd.
Turn right (south) on Pomerado Rd.
Immediately after crossing Monte Vista Rd., make a left turn into the office complex.
Our office is the first door on the south side of the building.

Coming from I-15 Northbound:
Take the Camino Del Norte exit
Turn right (east) onto Camino Del Norte
Turn left (north) on Pomerado Rd.
Turn right into the Pomerado Medical Dental Complex
Our office is the first door on the south side of the building

PATIENT INFORMATION FOR MEDICAL RECORD

PATIENT INFORMATION — PLEASE PRINT CLEARLY

_____ ☐ Male ☐ Female
LAST FIRST MI

BIRTHDATE ____/____/_____ AGE _____ Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Separated

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

BILLING ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE ( ) _____ CELL PHONE (voluntary) ( ) _____

SOCIAL SECURITY # _____ EMAIL ADDRESS (voluntary) _____

EMPLOYED BY _____ WORK PHONE ( ) _____ EXT _____

WORK ADDRESS _____ JOB TITLE _____

FULL TIME STUDENT? ☐ YES ☐ NO NAME & LOCATION OF SCHOOL: _____

HAVE YOU RECEIVED AUTHORIZATION FROM YOUR PRIMARY PHYSICIAN FOR THIS VISIT? ☐ YES ☐ NO ☐ N/A

SPOUSE INFORMATION — PLEASE PRINT CLEARLY

_____ BIRTHDATE ____/____/_____
LAST FIRST MI

SOCIAL SECURITY # _____ EMPLOYED BY _____

NAME OF PERSON LEGALLY RESPONSIBLE (PLEASE FILL IN ONLY IF PATIENT IS A MINOR, OR HAS A GUARDIAN)

NAME _____ RELATIONSHIP TO PATIENT _____

SOCIAL SECURITY # _____ BIRTHDATE ____/____/_____ EMAIL: _____

HOME PHONE ( ) _____ CELL PHONE (voluntary) ( ) _____

EMPLOYED BY _____ WORK PHONE ( ) _____ EXT: _____

MEDICAL INSURANCE INFORMATION — PLEASE PRINT CLEARLY

I. PRIMARY INSURANCE COMPANY _____

IDENTIFICATION NUMBER _____ SUBSCRIBER NAME: _____

II. SECONDARY INSURANCE COMPANY _____

IDENTIFICATION NUMBER _____ SUBSCRIBER NAME: _____

NAME OF PRIMARY PHYSICIAN _____ PHONE _____

I HEREBY AUTHORIZE DALE A. KOOISTRA, M.D., PH.D. TO TREAT THE ABOVE NAMED PATIENT AND WILL ASSUME FULL RESPONSIBIITY FOR PAYMENT OF SERVICES UNLESS OTHERWISE ARRANGED FOR AND AGREED UPON BY ALL PARTIES. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO OBTAIN ANY REQUIRED REFERRAL AUTHORIZATION PRIOR TO MY APPOINTMENT TIME.

FOR THE PURPOSE OF MEDICAL EVALUATION, I HEREBY CONSENT TO PRE- AND POST- TREATMENT DIGITAL PHOTOGRAPHS DURING THE COURSE OF THIS AND SUBSEQUENT VISITS. I UNDERSTAND THAT THESE IMAGES MAY BE IDENTIFIABLE AND WILL REMAIN A PART OF MY MEDICAL RECORD.

_____ _____
PATIENT SIGNATURE DATE

Dale A Kooistra, MD, PhD

Patient's Name: _____ **Patient's Height:** _____

Today's Date: _____ **Patient's Weight:** _____

List all prescription medications and dosages: _____

_____

_____

List any medication you are allergic to: _____

_____

_____

Do you have or have you had:

- ☐ Eczema
- ☐ Psoriasis
- ☐ Asthma/Lung Disease
- ☐ Pacemaker
- ☐ Blood Clots _____
- ☐ High Blood Pressure
- ☐ Gout
- ☐ Stroke
- ☐ Bleeding Problem
- ☐ Depression/Anxiety
- ☐ Bladder Problem
- ☐ Kidney Disease
- ☐ Stomach Ulcers
- ☐ Cataracts
- ☐ Anemia
- ☐ Abnormal Heart Beat/Arrythmia — If yes, what kind _____
- ☐ Heart Disease — If yes, what kind _____
- ☐ Prostate Trouble — If yes, what kind _____
- ☐ Hepatitis — If yes, what kind _____
- ☐ Skin Cancer — If yes, what kind _____
- ☐ Cancer — If yes, what kind _____

Social History:

Do you use tobacco? ☐ Yes ☐ No

If yes, what kind _____

How much _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, how much _____

History of Substance abuse: ☐ Yes ☐ No

If yes, what kind _____

Family History (Blood relatives only):

- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin Cancer

If yes, who in your family? _____

What kind of cancer? _____

Are you Allergic to: ☐ Latex ☐ Neosporin ☐ Bacitracin ☐ Bandages

Medical Problems: _____

_____

_____

Surgical History: _____

_____

_____

Are you on any blood thinners?

(incude Xarelto, Coumadin, Plavix, Wafarin, Pradaxa, Aspirin, Fish Oil, etc.)

Please specify: _____

List all Vitamins or Supplements you are taking: _____

_____

When in the sun, do you burn or tan? _____

Where did you grow up? _____

Dermatology
Surgery
Medical Group

Dale A. Kooistra, M.D., Ph.D.
www.drdalekooistra.com

15525 Pomerado Road • Suite D-2 • Poway, CA 92064 • (858) 675-8001 • Fax (858) 487-1337

Notice of Privacy Practices & Record of Disclosures

Phone calls and messages: Our front office provides a courtesy call to a number you designate to remind you of upcoming appointments. If we need to reach you for any other reason, we will NOT leave your personal information in a message; you will simply be asked to return our phone call. If you still do not want us to leave a message of any kind, please mark "NO."

May we leave a message on your answering machine or voicemail? Yes☐ No☐
Best daytime contact number: home ☐ cell ☐ work ☐

Authorization to release PHI: The HIPAA privacy rule gives you the right to restrict the uses and disclosures of your Protected Health Information (PHI). You also reserve the right to request confidential information about your record for yourself or for designated individuals. *Note: Your primary care physician is automatically included as a designated individual.*

I, _____ (**patient name**) give the physician, Dr. Dale Kooistra, or his office staff permission to discuss my medical condition and treatment with the following individual or individuals:

1) _____ _____
Name of person — Relationship to patient

_____ _____
Primary contact telephone number — Alternate telephone number

2) _____ _____
Name of person — Relationship to patient

_____ _____
Primary contact telephone number — Alternate telephone number

Assignment of Benefits:
I understand that I have been offered a copy of Dr. Kooistra's Notice of Privacy Practices. I hereby acknowledge that the above individuals have my permission to discuss my medical condition and treatment with Dr. Dale Kooistra and his medical staff. I understand that I reserve the right to change my permissions, but that I must notify Dr. Kooistra and his staff of any changes.

_____ _____
Patient Signature — **Date**

Dermatology
Surgery
Medical Group

Dale A. Kooistra, M.D., Ph.D.
www.drdalekooistra.com

15525 Pomerado Road • Suite D-2 • Poway, CA 92064 • (858) 675-8001 • Fax (858) 487-1337

Medical Insurance Office Policy

In order to meet the needs and requests of our patients, we are contracted with numerous health insurance programs.

We are very pleased to be able to provide these services to you, but it is extremely difficult for us to keep track of all the individual requirements of each plan. Each plan has different stipulations regarding what services we can provide, and where or how often they may be performed. Even within the same insurance company, plans differ depending upon the contract you or your employer has negotiated.

Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines if you let us know at EACH time of service exactly what those guidelines are.

Unfortunately, if you do not know or do not inform us of any special requirements in your insurance contract, and we subsequently order services that are not covered, such as lab work, excisions, cryosurgery, etc., we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

Please understand that, ultimately, you are responsible for understanding your own insurance plan and for communicating with our office and billing staff.

With your cooperation and help, you should be able to receive all of the benefits offered to you, and we will be able to concentrate on caring for your medical needs. If you have any billing-related questions, please contact our billing manager, Melissa, at (760) 741-0404 as soon as a question arises.

I have read and understand the office policy stated above and agree to accept responsibility as described, for the duration of my care. I understand that I will be notified of any changes Dr. Kooistra and his office staff make to this policy. I understand that any modification to this policy form by me renders it null and void.

_____

Patient name (please print)

_____

Patient signature **Date**