DERMATOLOGY CENTER OF WELLINGTON
PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, M.I.) _____

SS# _____ **AGE** _____ **DATE OF BIRTH** _____

□ SINGLE □ MARRIED □ DIVORCED □ WIDOWED _____ **SEX □ MALE □ FEMALE** _____

PRIMARY ADDRESS _____ **HOME PHONE ( )** _____

CITY _____ **STATE** _____ **ZIP** _____ **CELL PHONE ( )** _____

ALTERNATE ADDRESS (FROM _____ MONTH TO _____ MONTH) _____

CITY _____ **STATE** _____ **ZIP** _____ **HOME PHONE ( )** _____

EMAIL ADDRESS _____

POLICY HOLDER _____ **BIRTHDATE** _____

POLICY HOLDER SS# _____ **RELATIONSHIP** _____

ADDRESS _____

_____ **PHONE ( )** _____

PATIENT EMPLOYER _____ **OCCUPATION** _____

ADDRESS _____ **PHONE ( )** _____

NAME OF SPOUSE OR PARENTS _____

SPOUSE/PARENT EMPLOYER _____ **OCCUPATION** _____

ADDRESS _____ **PHONE ( )** _____

TO NOTIFY IN CASE OF EMERGENCY _____

RELATIONSHIP _____ **PHONE ( )** _____

PRIMARY CARE PHYSICIAN _____ **PHONE ( )** _____ **FAX ( )** _____

PHARMACY _____ **PHONE ( )** _____

INSURANCE INFORMATION:

□ PRIVATE/SELF PAY □ HMO □ PPO □ MEDICARE

PRIMARY INSURANCE:

INSURANCE COMPANY _____

POLICY # _____ **GROUP #** _____

CLAIMS ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

PHONE ( ) _____

SECONDARY INSURANCE: (IF APPLICABLE)

INSURANCE COMPANY _____

POLICY # _____ **GROUP #** _____

CLAIMS ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

PHONE ( ) _____

I HEREBY ACKNOWLEDGE THAT ALL OF THE ABOVE INFORMATION IS ACCURATE AND COMPLETE TO THE BEST OF MY ABILITY.

PATIENT NAME _____ **SIGNATURE** _____ **DATE** _____

PARENT OR AUTHORIZED REPRESENTATIVE: _____

DERMATOLOGY CENTER OF WELLINGTON
MEDICAL HISTORY

Patient: _____ Date of birth _____/_____/_____ Age _____
(Last) (First) (M.I.)

Personal History : (Please check all appropriate boxes)

Chicken pox	yes ☐	no ☐	Thyroid disease	yes ☐	no ☐	Aids/HIV	yes ☐	no ☐
Asthma	yes ☐	no ☐	Kidney disease	yes ☐	no ☐	Syphilis	yes ☐	no ☐
Rheumatic fever	yes ☐	no ☐	Bleeding disorder	yes ☐	no ☐	Herpes/cold sores	yes ☐	no ☐
Arrhythmia	yes ☐	no ☐	Anemia	yes ☐	no ☐	Venereal disease	yes ☐	no ☐
High blood pressure	yes ☐	no ☐	Eye disorder	yes ☐	no ☐	Keloids	yes ☐	no ☐
Heart murmur	yes ☐	no ☐	Depression	yes ☐	no ☐	Eczema	yes ☐	no ☐
Heart surgery	yes ☐	no ☐	Arthritis/Joint pain	yes ☐	no ☐	Skin infections	yes ☐	no ☐
Heart valve surgery	yes ☐	no ☐	Meningitis	yes ☐	no ☐	Shingles	yes ☐	no ☐
Mitral valve prolapse	yes ☐	no ☐	Migraine headaches	yes ☐	no ☐	Liver disease	yes ☐	no ☐
Pacemaker	yes ☐	no ☐	Epilepsy/Seizures	yes ☐	no ☐	Hepatitis	yes ☐	no ☐
Artificial joint	yes ☐	no ☐	Gastric ulcers	yes ☐	no ☐	Diabetes	yes ☐	no ☐
Tuberculosis	yes ☐	no ☐	Chron's/Colitis	yes ☐	no ☐	Hives	yes ☐	no ☐
COPD/Emphysema	yes ☐	no ☐	Other _____					

Skin History:

Have you ever had skin cancer ? yes ☐ no ☐ If yes, what type:_____
Has anyone in your family had skin cancer? yes ☐ no ☐ If yes, what type:_____
Any history of any skin disease? yes ☐ no ☐ If yes, please list:_____
Do you heal slowly? yes ☐ no ☐ Do you bleed easily or have prolonged bleeding? yes ☐ no ☐
Do you need to be pre-medicated before any surgery or teeth cleaning? yes ☐ no ☐

Medications: (Please list all medicines including aspirin, birth control pils, vitamins/supplements, diet pills, etc)

_____
_____

Allergies to medications: yes ☐ no ☐ If yes, please list medication (s) and what happens:

_____
_____

Allergies to Epinephrine	yes ☐	no ☐	If yes, what happens?_____
Latex	yes ☐	no ☐	If yes, what happens?_____
Lidocaine	yes ☐	no ☐	If yes, what happens?_____
Tape/Bandage	yes ☐	no ☐	If yes, what happens?_____
Anesthetic (local)	yes ☐	no ☐	If yes, what happens?_____

Surgery: (list all) ___ _____
Hospitalizations: _____
Social History:
Occupation _____ Employer _____
Alcohol? yes ☐ no ☐
Smoke ? yes ☐ no ☐
Snuff/smokeless tobacco ? yes ☐ no ☐
Recreational drugs? yes ☐ no ☐

Women: (Please complete) .
First day of last menstrual cycle _____ _ Pregnant yes ☐ no ☐
Number of pregnancies _____ Breast-feeding yes ☐ no ☐

How did you hear about our practice _____ Referred by: _____
I hereby acknowledge that all of the above information is accurate and complete to the best of my ability

Patient Name:_____ **Patient Signature**_____**Date**_____
Parent or authorized representative_____

DERMATOLOGY CENTER OF WELLINGTON

NEW PATIENT NOTICE OF PRIVACY
AND DISCLOSURE OF HEALTH INFORMATION

I understand that as a part of my healthcare, Dermatology Center of Wellington, and its physician(s) originate and maintain paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that as part of this organization's treatment, payment, and health care operations, it may become necessary to disclose my protected health information to another entity. I consent to such disclosure for these permitted uses, including disclosures via fax.

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

The complete Private Policy Notice of Dermatology Center of Wellington, and its physician(s) is available in the office for my perusal. I may also request my own copy if I desire.

I fully understand and accept the terms of this consent.

Patient Name (print): _____ Date: _____
Patient Signature: _____
Parent or Authorized representative (if applicable): _____
If patient is a minor (under 18) check relationship: ☐ mother ☐ father ☐ other _____

Please complete the following information:

Name of person(s) with whom we may discuss your medical information (i.e. wife/husband, child, etc)
Name: _____ Relation: _____
Name: _____ Relation: _____
Name: _____ Relation: _____

May we leave a message on your answering machine of the following:
Laboratory/ pathology results: ☐ yes ☐ no

Dermatology Center of Wellington

DISEASES & SURGERY OF THE SKIN, HAIR, AND NAILS

Statement of Financial Responsibility & Release of Information

1. **HMO / PPO / Commercial Insurance:**

I understand that Dermatology Center of Wellington, and its physician(s) will assist me in submitting my claim to my insurance carrier. I hereby authorize payment directly to Dermatology Center of Wellington, and its physician(s) of medical benefits, for the services provided. I understand that I am financially responsible for my health insurance deductibles, coinsurance, and non-covered services. I also understand that I am responsible for all necessary referrals if indicated by my insurance plan.

Name of patient_____ Date_____

Patient Signature _____ Parent/Guardian _____

2. **Medicare and Medicaid ONLY:**

Lifetime Authorization:

I certify that the information given by me in applying for payment under Title XVIII and/or title XIX of Social Security Act is correct, and request that said payment of authorized benefits are made on my behalf. I understand that I am financially responsible for my deductible, coinsurance, and non-covered services. I authorize any holder of medical information about me to release to the Social Security Administration or its intermediary carriers, any information needed for their Medicare/Medicaid claim. I hereby irrevocably assign payment to Dermatology Center of Wellington, and its physician(s) accepting assignment of all medical benefits applicable and otherwise payable to me. I also understand that Medicare will cover 80% of covered charges and I will be responsible for the other 20% unless covered by a supplemental insurance.

Signature as it appears on card_____ Date_____

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file: I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of my medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on card_____ Date_____

3. **Payment and Release of Information:**

I hereby assume responsibility to pay all costs of services provided by Dermatology Center of Wellington, and its physician(s) to the patient. My signature below signifies my understanding and willingness to comply with this policy. Dermatology Center of Wellington, reserves the right to discharge any patient from the practice if such patient does not show up for their appointment or does not cancel the appointment within 24 hours of the appointment.

*All payments are due at the time services are rendered unless prior arrangements have been made. Dermatology Center of Wellington will accept cash, checks, Visa, MasterCard, American Express, Discover and CareCredit for your convenience. I agree to be responsible for any cost incurred in the collection or litigation of any unpaid balance. Any returned check shall be subject to a $25 fee.

Name of patient_____ Date_____

Patient Signature _____ Parent/Guardian_____