

# Dermatology at Winghaven Registration

## PATIENT INFORMATION

**Name:** \_\_\_\_\_ **Sex:** \_\_\_\_\_  
Last First M.I.

**Address:** \_\_\_\_\_ **Marital Status:** \_\_\_\_\_  
Number Street City State Zip

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **SSN#:** \_\_\_\_\_ **Home No:** ( ) \_\_\_\_\_

**Work No:**( ) \_\_\_\_\_ **Cell No:** ( ) \_\_\_\_\_ (Please don't list a minors cell#)

**Employer:** \_\_\_\_\_ **Retired?:** \_\_\_\_ **Full Time Student:** \_\_\_\_\_

**Person to notify in case emergency:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
(Please list a person Not living in your home).

**Which phone number should we call first? Home** \_\_\_\_ **Work** \_\_\_\_ **Cell** \_\_\_\_ (Please put an X on appropriate line.)

**May we leave a message on your home answering machine?** Yes  No

**May we leave a message at your work to call us?** Yes  No

**May we discuss your medical condition with another person?** Yes  No

**If yes, Whom may we speak with?** \_\_\_\_\_ **Relationship** \_\_\_\_\_

## Primary Insurance Guarantor Information

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_/\_\_/\_\_ **Relationship To Patient** \_\_\_\_\_  
Last First M.I.

**Home Address:** \_\_\_\_\_  
Number Street City State Zip

**SSN:** \_\_\_\_\_ **Home No:** ( ) \_\_\_\_\_ **Work No:** ( ) \_\_\_\_\_ **Cell No:** ( ) \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_ **Id#:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

## Secondary Insurance Guarantor Information

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_/\_\_/\_\_ **Relationship To Patient** \_\_\_\_\_  
Last First M.I.

**Home Address:** \_\_\_\_\_  
Number Street City State Zip

**SSN:** \_\_\_\_\_ **Home No:** ( ) \_\_\_\_\_ **Work No:** ( ) \_\_\_\_\_ **Cell No:** ( ) \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_ **Id#:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Is the patient a minor?** Yes No (If yes, the accompanying adult must fill out below.)

**Name:** \_\_\_\_\_ **SSN#** \_\_\_\_\_ **Relationship to patient** \_\_\_\_\_

**DERMATOLOGY MEDICAL HISTORY**

*\*Welcome to our practice\**

Patient name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for appointment: \_\_\_\_\_

Referred by: \_\_\_\_\_

List all medications you are taking: <i>(over-the-counter and prescribed)</i>	

List all allergies: <i>(medications, topicals)</i>	
Allergy:	Reaction:

**Do you have now, or ever had diseases or conditions of: (Please check yes or no and fill in blanks, when applicable)**

<b>Lungs:</b>	YES	NO
Bronchitis:	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema:	<input type="checkbox"/>	<input type="checkbox"/>
Asthma:	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough :	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath:	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing :	<input type="checkbox"/>	<input type="checkbox"/>

<b>Infectious:</b>	YES	NO
Tuberculosis:	<input type="checkbox"/>	<input type="checkbox"/>
Yeast infections while on antibiotics:	<input type="checkbox"/>	<input type="checkbox"/>
Fever blisters/cold sores:	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis:	<input type="checkbox"/>	<input type="checkbox"/>
Tooth Abscess:	<input type="checkbox"/>	<input type="checkbox"/>

<b>Cardiovascular:</b>	YES	NO
Artificial valve:	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse:	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur:	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure:	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack:	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heartbeat:	<input type="checkbox"/>	<input type="checkbox"/>
History of rheumatic fever:	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker:	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots:	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain:	<input type="checkbox"/>	<input type="checkbox"/>

<b>Other systemic:</b>	YES	NO
Diabetes:	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problems:	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis:	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease:	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems:	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions, seizures, or epilepsy:	<input type="checkbox"/>	<input type="checkbox"/>
Fainting:	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Joint deformity:	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joint:	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease (Lupus,MS,etc):	<input type="checkbox"/>	<input type="checkbox"/>
History of cancer: type	<input type="checkbox"/>	<input type="checkbox"/>
Family history of cancer:	<input type="checkbox"/>	<input type="checkbox"/>
type	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever/seasonal allergies:	<input type="checkbox"/>	<input type="checkbox"/>
Require antibiotics prior to dental procedure:	<input type="checkbox"/>	<input type="checkbox"/>

<b>Gastrointestinal:</b>	YES	NO
Stomach absorptive disorder:	<input type="checkbox"/>	<input type="checkbox"/>
Nausea, vomiting or diarrhea when taking oral antibiotics:	<input type="checkbox"/>	<input type="checkbox"/>

<b>Women:</b>	YES	NO
Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Planning pregnancy in the near future?	<input type="checkbox"/>	<input type="checkbox"/>
Irregular menses?	<input type="checkbox"/>	<input type="checkbox"/>
Unwanted/Excessive facial or pubic hair growth?	<input type="checkbox"/>	<input type="checkbox"/>

<b>Social:</b>	YES	NO
Do you or have you ever smoked? If yes, how much?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol? If yes, How many drinks per day?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use IV or illicit drugs? If yes, what?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been exposed to HIV/AIDS or Hepatitis B or C?	<input type="checkbox"/>	<input type="checkbox"/>

What is your occupation? \_\_\_\_\_

<u>List any other diseases or conditions:</u>	<u>List any surgeries you have had and their dates:</u>

**Do you now, or have you ever had: (Please check yes or no, and fill in the blanks when applicable)**

<b>Skin:</b>	YES	NO	
History of melanoma:	<input type="checkbox"/>	<input type="checkbox"/>	If yes, where?
History of basal cell or squamous cell carcinoma:	<input type="checkbox"/>	<input type="checkbox"/>	If yes, where?
Family history of melanoma:	<input type="checkbox"/>	<input type="checkbox"/>	If yes, who?
Family history of basal cell or squamous cell carcinoma:	<input type="checkbox"/>	<input type="checkbox"/>	If yes, who?
A specific skin disease:	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what kind?
Problems healing:	<input type="checkbox"/>	<input type="checkbox"/>	
Scarring or keloids after surgery:	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty stopping bleeding:	<input type="checkbox"/>	<input type="checkbox"/>	
Photosensitivity:	<input type="checkbox"/>	<input type="checkbox"/>	
Skin rash to medications or food:	<input type="checkbox"/>	<input type="checkbox"/>	If yes, to what?

**\*Optional:**

<b>Would you be interested in learning more about the following cosmetic therapies offered here?</b>	YES	NO
Sclerotherapy for spider veins of the lower extremities	<input type="checkbox"/>	<input type="checkbox"/>
Chemical peels for photodamage or hyperpigmentation	<input type="checkbox"/>	<input type="checkbox"/>
Restylane/Perlane injections for facial wrinkles or lip contouring	<input type="checkbox"/>	<input type="checkbox"/>
Laser therapy for small facial vessels, vascular birthmarks, or tattoo removal	<input type="checkbox"/>	<input type="checkbox"/>
BOTOX for facial wrinkles	<input type="checkbox"/>	<input type="checkbox"/>

To the best of my knowledge, I signify the above health history taken to be true and accurate.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Person Authorized to Complete Medical History

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

**Patient Financial Policy**

(Please initial each line to express your understanding)

1. \_\_\_\_ This office contracts with Medicare and many managed care plans. Please check with our reception staff to determine whether your plan is one of these. If we have a contract with your plan, we will file a claim on your behalf with your insurance company, and accept their assignment. Managed care plans that we are contracted with require us to collect a co-pay at the time of service. The deductible and/or co-insurance are billed to the patient after the insurance company has processed the claim. If you are uncertain, please check with your managed care plan regarding what payment(co-pay) is required at the time of service.
2. \_\_\_\_ If you do not have one of the plans with which the practice is contracted, the total cost of your visit is required at the time of service. In this situation, you will be asked to sign a waiver explaining your financial responsibility in greater detail prior to your office visit. After your visit, we will provide along with a receipt, an itemized statement that you can file with your insurance company for possible reimbursement.
3. \_\_\_\_ Not all insurance plans cover all dermatological services. Such non-covered services may include but are not limited to, *skin tag removal, benign skin lesion removals, treatment of fungal nail infections, treatment for melasma or hyper/hypopigmentation disorders of the skin, biological response modifiers for psoriasis and various cosmetic procedures.* Before the non-covered service is provided, the physician will advise you that the service may not be covered and will go over the cost. **Patients are encouraged to check with their insurance company on what dermatological services are covered prior to their visit.** Unfortunately, it is impossible for us to keep up with what is covered per plan per policy per patient. Payment for all non-covered services is due at the time of service.
4. \_\_\_\_ If your plan requires a referral from your primary care physician for your visit with us to be covered, please check with reception and make sure that the referral has been received prior to your visit. If there is no referral, and you have this type of insurance, the office visit will not be covered, and you will be held financially responsible for the visit at the time of service.
5. \_\_\_\_ In separation or divorce cases, the patient or the parent bringing in the minor to the appointment will be held financially responsible. The divorce decree only involves the divorcees and the state and we reject any further involvement. However, we will need permission from the insured to bill the insurance company.
6. \_\_\_\_ The practice requires advanced notice for appointment cancellations. A **\$25.00 fee** will be charged to the patient's account if a patient fails to give advanced notice and does not show for their scheduled appointment. A **\$50.00 fee** will be assessed if a patient does not give advanced notice and fails to show for a scheduled surgical procedure. If these incidents occur more than three times; the patient will be dismissed from the practice.
7. \_\_\_\_ For amounts due to the practice, a **single statement** will be sent to your address. You have 30 days after this statement to pay in full the balance indicated on the statement. If no payment is received, the credit card listed below will be charged for any outstanding balances. Outstanding balances over 60 days old will be forwarded to a third party for collection and a fee of 33% will be added to the outstanding amount that is owed. **No additional contact will be made by our office at that point.**
8. \_\_\_\_ This office requires a credit card or debit card on file to cover outstanding account balances. **The card will not be charged without prior notification.** For your convenience, we accept MasterCard, Visa, Discover, and American Express.  
Please check one: \_\_\_ VISA \_\_\_ Mastercard \_\_\_ American Express \_\_\_ Discover

Exp Date: \_\_\_\_\_ Security Code: \_\_\_\_\_ Account Number: \_\_\_\_\_

**I have read and understand the practice's patient financial policy and agree to be bound by its terms. I also understand and agree that such terms may be periodically amended by the practice.**

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Print Patient Name

Patient Signature

Date

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Signature of person Authorized to Consent

Relationship to Patient

Patient Date of Birth

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Thank you for choosing Dermatology at WingHaven, L.L.C. for your health care needs.

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our Notice.

\_\_\_\_\_  
Signature of Patient (or Legal Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Staff Member                      Title

\_\_\_\_\_  
Date

Comments:

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

**ASSIGNMENT OF BENEFITS**

**ALL INSURANCE EXCEPT MEDICARE**

I authorize my insurance company to pay benefits on my behalf directly to **Dermatology at WingHaven**. I authorize **Dermatology at WingHaven** to provide to my insurance company, any information necessary to process claims for services rendered to me.

\_\_\_\_\_  
Signature as it appears on insurance card

\_\_\_\_\_  
Date

**MEDICARE**

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration 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 to either myself or the party who accepts assignment. Regulations pertaining Medicare assignment of benefits apply.

\_\_\_\_\_  
Signature as it appears on Medicare Card

\_\_\_\_\_  
Date

**MEDIGAP**

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 authorize Medigap benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to my Medigap carrier any information needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_  
Signature as it appears on Medigap Card

\_\_\_\_\_  
Date

Yes or No      Do you or your spouse work in a company which has more than 20 employees and have insurance coverage through that job?

Yes or No      Are you covered by any other insurance that makes Medicare secondary?