

Print name:

WILMINGTON DERMATOLOGY CENTER PATIENT HISTORY FORM

Instructions: Please fill out each bubble completely

MEDICAL HISTORY

- | | | |
|---|---------------------------|--------------------------|
| History of melanoma | <input type="radio"/> Yes | <input type="radio"/> No |
| History of squamous cell carcinoma (SCC) | <input type="radio"/> Yes | <input type="radio"/> No |
| History of basal cell carcinoma (BCC) | <input type="radio"/> Yes | <input type="radio"/> No |
| Change in size, shape, color or sensation in any moles or growths | <input type="radio"/> Yes | <input type="radio"/> No |
| Hypertension (HTN) [High Blood Pressure] | <input type="radio"/> Yes | <input type="radio"/> No |
| Hypercholesterolemia [High Cholesterol] | <input type="radio"/> Yes | <input type="radio"/> No |
| Liver disease | <input type="radio"/> Yes | <input type="radio"/> No |
| Diabetes | <input type="radio"/> Yes | <input type="radio"/> No |
| Neurological disorders | <input type="radio"/> Yes | <input type="radio"/> No |
| Cancer | <input type="radio"/> Yes | <input type="radio"/> No |
| Asthma/allergies | <input type="radio"/> Yes | <input type="radio"/> No |
| Thyroid disease | <input type="radio"/> Yes | <input type="radio"/> No |
| Pacemaker | <input type="radio"/> Yes | <input type="radio"/> No |
| Bleeding Disorder | <input type="radio"/> Yes | <input type="radio"/> No |
| Cardiac Valve Disease/Mitral Valve Prolapse | <input type="radio"/> Yes | <input type="radio"/> No |
| Joint Replacement | <input type="radio"/> Yes | <input type="radio"/> No |
| Joint pain/arthritis | <input type="radio"/> Yes | <input type="radio"/> No |
| Autoimmune disease | <input type="radio"/> Yes | <input type="radio"/> No |
| Currently Pregnant | <input type="radio"/> Yes | <input type="radio"/> No |
| Currently Breast feeding | <input type="radio"/> Yes | <input type="radio"/> No |
| Current Irregular periods | <input type="radio"/> Yes | <input type="radio"/> No |

FAMILY HISTORY

- | | | |
|----------|---------------------------|--------------------------|
| Melanoma | <input type="radio"/> Yes | <input type="radio"/> No |
|----------|---------------------------|--------------------------|

SOCIAL HISTORY

- | | | |
|-------------------|---------------------------|--------------------------|
| Currently Smoking | <input type="radio"/> Yes | <input type="radio"/> No |
|-------------------|---------------------------|--------------------------|
- How often did you have a drink containing alcohol in the past year?
- | | | | |
|--|--|--|---|
| <input type="radio"/> never | <input type="radio"/> monthly or less | <input type="radio"/> 2 to 4 times a month | <input type="radio"/> 2 to 3 times a week |
| <input type="radio"/> 4 or more times a week | <input type="radio"/> 6 or more times a week | | |



THIS SECTION MUST BE COMPLETED BY ALL NEW PATIENTS:

Today's Date ____ / ____ / ____

Name: _____
Last First Middle Initial

Mailing Address _____

Home Phone: () _____ Other: () _____
City State Zip

Patient's Occupation: _____ Work Phone: () _____ Ext: _____

Date of Birth: ____ / ____ / ____ Age: ____ Sex: Male Female

Email address: _____

May we contact you at: Home Cell Work (check all that apply)

May we leave a message on your answering machine regarding lab/visit/biopsy results? Yes No

May we leave a message with any other person? Yes No Name: _____

Emergency Contact: _____ Relationship: _____ Contact Number: _____

Preferred Pharmacy: _____ Street Name _____ Phone#: _____

RESPONSIBLE PARTY (if different from patient)

Name: _____
Last First Middle Initial

Address: _____

Home Phone: () _____ Work Phone: () _____
City State Zip

Date of Birth: ____ / ____ / ____ Sex : Male Female

Referred By: _____ **Primary Care Physician (if different)** _____

How did you hear about us (friend, advertisement, internet, yellow pages etc. – please describe) _____

I authorize release of medical information to my primary care doctor or referring physician or other consultants if needed. Signature: _____ **Date:** _____

Dr. George recommends that all patients are who are older than 20 have a comprehensive skin exam to screen for skin cancer. (Please check one)

I request a total body exam (included in standard skin check visit) _____

I decline a total body exam _____

Turn Page Over to Complete

You are not required to complete the information on this page if you provide your insurance cards to be scanned

INSURANCE COVERAGE – PRIMARY

*(Note: If you provided your primary insurance card to the receptionist, you only need to fill out the **italicized areas** within this section)*

Insurance Co. Name: _____ Phone: () _____ Ext: _____

Address of Claim Center: _____

Name Policy Holder (Insured): _____ City _____ State _____ Zip _____
Date of Birth: ____/____/____

Policy #: _____ Group #: _____

Policy Type: *HMO* *PPO* Employer Name: _____

Employer Address _____

If Patient is a child, check relationship: Mother _____ Father _____ Other _____

INSURANCE COVERAGE – SECONDARY

*(Note: If you provided your secondary insurance card to the receptionist, you only need to fill out the **italicized areas** within this section)*

Insurance Co. Name: _____ Phone: () _____ Ext: _____

Address of Claim Center: _____

Name Policy Holder (Insured): _____ City _____ State _____ Zip _____
Date of Birth: ____/____/____

Policy #: _____ Group #: _____

Policy Type: *HMO* *PPO* Employer Name: _____

Employer Address _____

If Patient is a child, check relationship: Mother _____ Father _____ Other _____

Wilmington Dermatology Center Conditions of Registration and Financial Policy

Patient Name: _____ Date of Birth: _____

The following are our conditions of registration as well as our policies with respect to the billing and collections of your account. By signing below, you are agreeing to be bound by these terms.

BASIC POLICY: Payment is due in full at the time service is provided in our office.

FOR PATIENTS WITH MEDICARE: We will bill Medicare on your behalf. As a courtesy, we will also bill secondary insurance carriers on your behalf. You are responsible for all co-insurance payments.

FOR PATIENTS WITH INSURANCE: All co-payments and deductibles are due at the time of service. We will bill insurance carriers on your behalf if we have a current contract with the carrier. Please be advised that your agreement with your insurance carrier is a private one and that ultimately, you are responsible for payment. If an insurance carrier has not paid a claim within 60 days of billing, our fees are due and payable from you. Our office will always strive to help you obtain the maximum possible coverage. It is, however, the patient's ultimate responsibility to determine the extent of coverage allowed by the insurance company.

In addition, preauthorization of a procedure is not a guarantee for payment. Any procedure may be considered not covered under the terms of your agreement with your insurance company. Your insurance carrier will make a determination of payment once the claim is received and reviewed. If after the claim is reviewed and it is determined by your insurance company that the procedure is **not** covered (cosmetic or not medically necessary), you will be financially responsible to Wilmington Dermatology Center, PLLC for the charges and will be billed for those services not covered by your insurance company.

NONCOVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or immediately upon notice of insurance claim denial.

MISSED APPOINTMENTS: In fairness to other patients and the doctor, we require at least 24 hours notice to cancel an appointment. You may be charged \$50.00 for each appointment that was missed or not canceled with 24 hour notice. Missing more than two appointments without providing 24 hours notice is grounds for discharge from the practice.

RETURNED CHECKS: There will be a fee of \$25.00 charged by this office for each check returned to us by your bank.

COLLECTION AGENCY COSTS: In the event that your account is forwarded to a collection agency, you agree to pay an additional fee equal to 33% of the balance forwarded to the collection agency and any additional attorney fees or court costs.

Turn Page Over to Complete

MEDICARE PATIENTS ONLY: SIGNATURE ON FILE. I request and authorize payments of Medicare benefits be made to Wilmington Dermatology Center, PLLC for any services furnished me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Service and its agents any information needed to adjudicate these benefits for services. I understand my signature requests that payment be made and authorizes release of all information necessary to adjudicate the claim. If “other health insurance” is indicated, my signature authorizes the release of all information to the insurer or agency that is necessary to adjudicate the claim. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and that I am responsible for the deductible, co-insurance, and any non-covered services.

Signature: _____ Date: _____

All Patients - ASSIGNMENT OF INSURANCE BENEFITS. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Wilmington Dermatology Center, PLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not the charges are paid by said insurance. I hereby authorized said assignee to release all information necessary to adjudicate all claims and secure payment for services rendered.

Signature: _____ **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 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 MEDIGAP Card _____ Date ____ / ____ / ____

All Patients - I have read, understood, and agree to be bound by the terms of this financial policy.

Signature: _____ **Date:** _____

**ACKNOWLEDGEMENT OF RECEIPT OF THE
NOTICE OF PRIVACY PRACTICES
OF WILMINGTON DERMATOLOGY CENTER, PLLC**

Patient: _____

DOB: _____

I hereby acknowledge that I had the opportunity to review the Notice of Privacy Practices of Wilmington Dermatology Center, PLLC. I understand that the Notice of Privacy Practices sets forth my rights relating to the use and disclosure of my personal health information and explains how Wilmington Dermatology Center, PLLC can use and/or disclose my personal health information both with and without my authorization. I understand that I am entitled to receive a copy of the Notice of Privacy Practices* if I so desire. I further understand that I may contact Dr. George if I have any questions regarding the contents of this Notice of Privacy Practices or to file a complaint about the privacy practices of Wilmington Dermatology Center, PLLC.

Signature of Patient or Patient's
Representative

Date

*A copy of our Notice of Privacy Practices can be found on our web site, www.wilmingtondermatologycenter.com. Go to the Patient Information page and click on the Notice of Privacy Practices link. A written copy is also available for review in the office.

Turn Page Over

WDC Skin Care Questionnaire

1. Do you follow a structured skin care regimen today? (Y) or (N)
a. If Yes – Describe your regimen: _____
2. Would you best describe your skin as oily, dry, or a combination? _____
3. How would you describe your skin's sensitivity? () LOW () MODERATE () HIGH
4. What are your primary skin-related concerns / goals?
 - a. _____
 - b. _____
 - c. _____

Facial Goals: List the location of your area of concern on the line

- () Correct Facial Sagging, Eyebrow Drop, improve jaw line definition _____
- () Improve volume in areas (cheeks, lips, etc) _____
- () Correct facial wrinkles/creases _____
- () Improve acne / rosacea _____
- () Get rid of facial veins and/or redness _____
- () Correct scarring _____
- () Correct sunspots _____
- () Correct precancerous spots _____
- () Improve general appearance of skin tone / health _____
- () Lengthen and thicken eye lashes _____

Body Related Goals: List the location of your area of concern on the line

- () Remove unwanted areas of fat _____
- () Remove tattoos _____
- () Tighten loose skin on arms, and above knees _____
- () Improve texture of skin (ex. Bumps on backs of arms) _____
- () Manage chronic skin conditions (ex. psoriasis, eczema) _____
- () Remove unwanted areas of hair _____

If you would like to be added to our monthly skincare e-newsletter, which includes educational information on skin care, new products & services, and specials; please add your email address below:

Email: _____

Learn more about our products and services in our waiting room – scan the QR code with your smart phone to visit our website.

