

Welcome To Our Office - Please Complete The Following Patient Registration Information

Last Name _____ First _____ M.I. _____ DATE _____

Date of Birth ____ / ____ / ____ Social Security # _____ Sex: M F

Marital Status: Single Married Domestic Partner Divorced Widowed

Mailing Address _____

City _____ State _____ Zip Code _____

Occupation _____ Employer _____

I was referred by _____

Primary Care Physician Name & Phone Number _____

Emergency Contact _____ Phone number _____

Relationship _____ Address _____

To respect your privacy, please list only the phone numbers that we may call and leave messages:

Home _____ Work _____ Cell _____

Do you give our practice permission to discuss your confidential medical information with a family member or other person you designate? **YES** **NO** *(IF YES, please provide their information below)*

Name _____ Phone number _____ Relationship _____

Would you like to receive our email newsletter? **YES** **NO** *(If YES, please provide your email below)*

E-mail: _____

An insurance card will be required at each visit if you would like us to bill your participating insurance. If you are not the responsible party (i.e., if you are insured under the plan of a spouse/parent) please list their information below:

Last Name _____ First _____ M.I. _____

Mailing Address _____

City _____ State _____ Zip Code _____

Date of Birth ____ / ____ / ____ Social Security # _____

The above is true and correct to the best of my knowledge: *(If under age 18, signature of parent or guardian)*

Signature _____ Date _____



Medical History

Last Name _____ First _____ M.I. _____ DATE _____

Past Medical History: Please Circle Any Past or Present Medical Conditions

Diabetes	Cancer	Asthma	Pacemaker/other heart device
High blood pressure	Thyroid disease	Depression	Kidney disease
Heart disease	HIV	Hepatitis	Liver disease
Artificial heart valve	GI/Stomach problems	Bleeding Disorder	Artificial joints
Other _____			

Surgeries/hospitalizations (list details): _____

Medications: Please list all medications you are currently taking (including supplements and over-the-counter):

Allergies: Are you allergic to any medications? **YES** **NO** (If YES, please list):

Are you currently pregnant or lactating? **YES** **NO**

Do you smoke? **YES** **NO**

Have you ever had a skin cancer? **YES** **NO**

If YES, please describe: _____

Is there a family history of skin cancer? **YES** **NO**

If YES, please describe: _____

General Review Of Systems:

Do you have a history of any of the following? (If YES, please circle):

Difficulty healing Formation of keloid scars Excessive bleeding Allergic reaction to tape/bandage

Have you recently experienced any of the following? (If YES, please circle):

Fever/Weight Loss	Infection	Difficulty Breathing	Vision Problems
Psychiatric Problems	Urination Problems	Joint/Muscle Pain	Chest Pain/Palpitations
Abdominal Pain	Neurological Problems	Other: _____	

The above is true and correct to the best of my knowledge: (If under age 18, signature of parent or guardian)

Signature _____ Date _____

Policies and Consents

Financial Policy

We make every effort to provide the finest dermatologic care. We appreciate your assistance in facilitating payment to ensure we can continue to provide such care. Payment is due in full at the time of service, including insurance co-payments. We accept cash, checks, MasterCard and Visa. As a courtesy, we accept direct payment from participating insurance plans for the portion of the fee that they pay.

Dermatology Billing Associates is our billing service. They process billing according to your insurance company’s policies. Please note that although a service may be ‘covered’ by your insurance plan, depending on any deductible, co-payment or co-insurance due, you may be responsible for all or part of the ‘covered’ amount. We are contractually obligated to collect this amount as determined by your insurance company. Should a balance be due, Dermatology Billing Associates will issue a bill. We cannot predict what your plan may or may not require you to pay, as every insurance policy has different coverage, deductible and co-insurance specifications – these are determined by your employer and its plan. It is your responsibility to be aware of any restrictions, limitations and requirements of your insurance policy.

In addition, please note that:

- If we are unable to confirm your insurance coverage at the time of your visit, a deposit may be required.
- Patients requiring a referral are responsible for obtaining referrals prior to the appointment.
- Biopsy and surgical specimens are sent to an outside lab for examination – the lab bills your insurance separately for their services.
- Missed appointments or those cancelled with less than 24 hours notice may be assessed a cancellation fee.

We are participating providers with Medicare and accept assignment on all medically necessary claims. Medicare patients are responsible for meeting their annual deductible and paying the 20% co-payment. We do file with secondary/supplemental carriers. However, if the secondary does not pay within 60 days, patients will be billed the remaining balance.

Consents

1. **Financial Policy:** I hereby certify that I have read, understand and agree to abide by the above financial policy. I authorize direct payment of insurance benefits to John K. Wildemore, M.D., LLC for services rendered and I authorize the release of medical information as necessary to my insurer and other institutions/agencies for payment of benefits.
2. **Medical Treatment & Photographs:** I consent to the performance of tests, procedures and medical photographs during the course of my care in the practice of John K. Wildemore, M.D., LLC for evaluation, diagnosis and treatment of my condition(s) as recommended and explained to me by my physician.
3. **Receipt Of Notice Of Privacy Practices:** I have reviewed a copy of this practice’s Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices) and all of my questions have been answered to my satisfaction. By signing below, I consent to the use and disclosure of protected health information for treatment, payment and health care operations. I understand that the terms of the Notice may change, and if they do, a revised copy may be obtained by contacting the office. I understand I have the right to revoke this consent in writing. However, such a revocation shall not affect any disclosures that have already been made in reliance on my prior consent

My signature below indicates that I have read, understand, and agree to all of the above statements.

Patient Signature _____ Date _____

If under age 18, parent/guardian signature _____ *Date* _____