



# PATIENT DEMOGRAPHICS

LAST NAME   
 FIRST NAME   
 MIDDLE NAME   
 PREFER TO BE CALLED   
 ADDRESS   
 UNIT   
 CITY, STATE, ZIP   
 HOME PHONE   
 WORK PHONE   
 CELL PHONE   
 EMAIL   
 DATE OF BIRTH

SEX  FEMALE  MALE  
 MARITAL STATUS  SINGLE  MARRIED  PARTNERED  DIVORCED  
 OTHER: \_\_\_\_\_  
 RACE  WHITE  BLACK OR AFRICAN AMERICAN  ASIAN  
 HISPANIC  OTHER  
 ETHNICITY  NOT HISPANIC OR LATINO  HISPANIC OR LATINO  
 SOCIAL SECURITY NUMBER   
 PRIMARY CARE DOCTOR NAME   
 PHONE   
 REFERRING DOCTOR NAME   
 PHONE   
 EMPLOYER NAME   
 EMERGENCY CONTACT   
 CONTACT PHONE & RELATION   
 PHARMACY OF CHOICE & LOCATION

## PARENT OR GUARDIAN IF PATIENT IS A MINOR

PARENT/GUARDIAN NAME  RELATION TO PATIENT   
 SOCIAL SECURITY NUMBER  IS PARENT/GUARDIAN A PATIENT OF WESTSIDE DERMATOLOGY? YES NO EMPLOYER   
 BILLING ADDRESS (IF DIFFERENT THAN ABOVE)  HOME PHONE  WORK PHONE

## INSURANCE INFORMATION

PRIMARY  
 PRIMARY INSURANCE NAME   
 INSURANCE ADDRESS   
 SUBSCRIBER NAME   
 SUBSCRIBER ADDRESS   
 SUBSCRIBER ID NUMBER   
 GROUP NUMBER   
 EMPLOYER / GROUP NAME   
 PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER:

SECONDARY  
 SECONDARY INSURANCE NAME   
 INSURANCE ADDRESS   
 SUBSCRIBER NAME   
 SUBSCRIBER ADDRESS   
 SUBSCRIBER ID NUMBER   
 GROUP NUMBER   
 EMPLOYER / GROUP NAME   
 PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER:

**PATIENT MEDICAL HISTORY**



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Are you allergic to any medications?  Yes  No If yes, please list: \_\_\_\_\_

Have you ever had dental anesthesia (novocaine)?  Yes  No Any bad reaction?  Yes  No

List all medications you are currently taking (including prescriptions, over the counter medicines, vitamins and herbals):

***Do you have now or have you ever had diseases or conditions (please check YES or NO)***

	YES	NO		YES	NO		YES	NO
Have you ever had skin cancer? (If yes, circle type) Basal Squamous Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family had skin cancer? (If yes, circle type) Basal Squamous Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of specific skin diseases? If yes: _____	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Do you have problems with healing?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Do you develop thick scars after surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>
Do you bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>
Do you develop skin rashes in reaction to: <input type="checkbox"/> Medications <input type="checkbox"/> Food <input type="checkbox"/> Environment <input type="checkbox"/> Bandages <input type="checkbox"/> Topical Neosporin <input type="checkbox"/> Other: _____			Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
			Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
			Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Limited Motion	<input type="checkbox"/>	<input type="checkbox"/>
			Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>

Please List Any Other Conditions You May Have:

***Social History***

	YES	NO
Do you drink alcohol If yes, _____ drinks per day	<input type="checkbox"/>	<input type="checkbox"/>
Do you use IV drugs? If yes, what? _____ How often? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke? If yes, how often? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or been exposed to HIV (AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>
(Women) Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
What is your occupation? _____		
Hobbies? _____		

***Other Concerns & Interests (optional)***

	YES	NO
Aluma Skin Tightening	<input type="checkbox"/>	<input type="checkbox"/>
Botox	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Peels / Medical Facials / Microdermabrasion	<input type="checkbox"/>	<input type="checkbox"/>
Laser Hair Removal	<input type="checkbox"/>	<input type="checkbox"/>
Laser Vein & Spot Removal	<input type="checkbox"/>	<input type="checkbox"/>
IPL Photo Rejuvenation	<input type="checkbox"/>	<input type="checkbox"/>
Juvederm / Restylane - Dermal Fillers	<input type="checkbox"/>	<input type="checkbox"/>
Sclerotherapy for "Spider Veins" On The Legs	<input type="checkbox"/>	<input type="checkbox"/>
Latisse	<input type="checkbox"/>	<input type="checkbox"/>
Mineral Makeup by Jane Iredale	<input type="checkbox"/>	<input type="checkbox"/>
Clarisonic PRO Skin Cleansing System	<input type="checkbox"/>	<input type="checkbox"/>
Would You Like To Schedule A Skin Care Consultation With Our Aesthetician?	<input type="checkbox"/>	<input type="checkbox"/>

***Family History***

	YES	NO
Acne	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma, Hayfever, Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Please list any other significant medical issues in your family: _____ _____		

***How Did You Learn of Westside Dermatology?***

- My Doctor: \_\_\_\_\_
- Friend / Family / Another Patient
- Other: \_\_\_\_\_

*Thank you for completing this questionnaire. We value you as a patient and hope you enjoy your visit today.*

**X** \_\_\_\_\_  
Patient Signature Date Reviewed By (Provider's Signature) Date



See Back

# PATIENT AGREEMENT



## Release of Information and Assignment of Insurance Benefits

I hereby authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of insurance benefits to the physician directly.

## Receipt of Notice of Privacy Practices

My signature below indicates I have reviewed a copy of my physician's Notice of Privacy Practices.

## Payment Policy

I certify the information I've provided for payment of services rendered for government or private health insurance is correct. I understand I am financially responsible to the physician for any balance due from any deductibles, co-payments, co-insurance, or in the event I have no insurance or my insurance does not cover services provided to me. I understand I am financially responsible for all services incurred. Physician reserves the right to impose reasonable financing/late fees as well as reasonable costs, attorney fees and/or expenses incurred in the collection of my account should it become delinquent. The following fees apply to patient accounts: \$5.00 if co-payment is not made at time of service; \$2.00 per month or 1% of balance (whichever is greater) on billed items 30 days past due; \$15 returned check; \$50.00—\$150.00 missed appointment or appointment cancelled within 48 hours (two business days).

## Insurance Coverage

**MEDICARE:** Westside Dermatology is a Medicare participating provider and accepts assignment on all non-cosmetic claims. I understand I am responsible for meeting the annual \$140.00+ deductible and the co-insurance balance remaining on each claim. I agree to direct any grievances regarding the method of how my claim benefits were calculated directly to Medicare. Furthermore, this office is required to keep my signature on file authorizing them to file claims to Medicare on my behalf and to release information to that payer if they require it to properly consider a claim. I authorize any holder of medical or other information about me to release it 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 either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

**COMMERCIAL** (Aetna, Cigna, First Choice, Great West, Premera, Regence, Uniform, United, etc): I will be responsible for paying my annual deductible, co-payment, and charges for any service/procedure deemed not medically necessary or cosmetic by my insurance. I acknowledge I am responsible for any balance remaining after my insurance processes my claim. I agree to direct any grievances regarding the method of how my claim benefits were calculated directly to my insurance.

**SECONDARY INSURANCE:** I understand Westside Dermatology will bill my secondary insurance plan as a courtesy and will do so for me once per claim and is under no obligation to pursue reimbursement 30 days after the claim is originally filed. (Note: tertiary insurance is not billed by Westside Dermatology.)

**NON-NETWORK INSURANCE:** I understand my insurance does not consider my Westside Dermatology physician to be a preferred provider and may pay my claims at a lower rate or not at all.

**UNINSURED:** I understand that payment in full is due upon receiving care and I agree to ask the provider how much services will be prior to having them performed.

## COMMUNICATIONS

Do we have permission to:

- |                                                                   |                              |                             |
|-------------------------------------------------------------------|------------------------------|-----------------------------|
| Leave a message on your voicemail/answering machine at home?      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Leave a message on your voicemail/answering machine at work?      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Discuss your medical condition with any member of your household? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If yes, who? \_\_\_\_\_ Relation: \_\_\_\_\_

\_\_\_\_\_  
Signature of patient (or guardian if a minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of patient

\_\_\_\_\_  
Print name of guardian (if patient is a minor)