Westside DERMATOLOGY

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	
PRIMARY CARE DOCTOR — PHONE	
REFERRING DOCTOR — NAME	
REFERRING DOCTOR — 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		SECONDARY	
PRIMARY INSURANCE NAME		SECONDARY INSURANCE NAME	
INSURANCE ADDRESS		INSURANCE ADDRESS	
SUBSCRIBER NAME		SUBSCRIBER NAME	
SUBSCRIBER ADDRESS		SUBSCRIBER ADDRESS	
SUBSCRIBER ID NUMBER		SUBSCRIBER ID NUMBER	
GROUP NUMBER		GROUP NUMBER	
EMPLOYER / GROUP NAME		EMPLOYER / GROUP NAME	
PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER:		PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER:	

PATIENT MEDICAL HISTORY

Westside DERMATOLOGY

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
Have you ever had skin cancer?	☐	☐
(If yes, circle type) Basal Squamous Melanoma		
Has anyone in your family had skin cancer?	☐	☐
(If yes, circle type) Basal Squamous Melanoma		
Do you have a history of specific skin diseases?	☐	☐
If yes: _____		
_____		
Do you have problems with healing?	☐	☐
Do you develop thick scars after surgery?	☐	☐
Do you bleed easily?	☐	☐
Do you develop skin rashes in reaction to:		
☐ Medications ☐ Food ☐ Environment		
☐ Bandages ☐ Topical Neosporin		
☐ Other: _____		

	YES	NO
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Phlebitis	☐	☐
Pacemaker	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐

	YES	NO
Shortness of breath	☐	☐
Diabetes	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Bladder Infections	☐	☐
Gastrointestinal Problems	☐	☐
Arthritis/Joint Deformity	☐	☐
Joint Pain	☐	☐
Limited Motion	☐	☐
Artificial Joint	☐	☐

Please List Any Other Conditions You May Have:

_____

_____

Social History

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

Family History

	YES	NO
Acne	☐	☐
Psoriasis	☐	☐
Asthma, Hayfever, Eczema	☐	☐
Please list any other significant medical issues in your family:		
_____		
_____		

Other Concerns & Interests (optional)

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

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.

See Back

X_____ _____

Patient Signature Date Reviewed By (Provider's Signature) Date

PATIENT AGREEMENT

Westside DERMATOLOGY

Release of Information and Assignment of Insurance Benefits

I herby 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 (which ever is greater) on billed items 30 days past due; $18 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?	□ Yes	□ No
Leave a message on your voicemail/answering machine at work?	□ Yes	□ No
Discuss your medical condition with any member of your household?	□ Yes	□ 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)