QuestQuanum™

WILSON DERMATOLOGY & SKIN CARE
PATIENT REGISTRATION
(Please Print)

Today's Date

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Preferred Phone Number Home ❑ Cell ❑ Work ❑
Street Address		Birthdate			Home Phone #
City	State / Zip Code		Work Phone #		Cell Phone # Text Messages Are Ok as Appointment Reminders ❑
Primary Care Physician	Primary Care Address				Primary Care Phone #

Email for Confirmations

INSURANCE INFORMATION

(Please give your insurance cards to the receptionist.)

Policy Holder's Name	Birthdate	Address (if different)	Phone #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

Policy Holder's Name of Secondary Insurance (if applicable)

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of Emergency Contact	Relationship to patient	Phone #

SIGNATURE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Wilson Dermatology & skin care or insurance company to release any information required to process my claims.

Patient/Guardian Signature *Date*

Wilson Dermatology & Skin Care
447 Woodbourne Road
Langhorne, PA 19047
Phone: (215) 486-8272 Fax: (215) 757-3600
www.wilsonderm.com

HIPAA Privacy Receipt of Privacy Practices Acknowledgement

I understand that as part of my health care, Wilson Dermatology & Skin Care originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided (master copy posted in waiting area) with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review the facility's Notice of Privacy Practices prior to signing this acknowledgment.
- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

_____ _____
Printed Name of Patient/Legal Representative Relationship to Patient

_____ ____/____/_____
Signature of Patient or Legal Representative Date

As a patient of Wilson Dermatology & Skin Care, from time to time we may need to communicate with you. To preserve your privacy, please indicate your preferred method for us to communicate medical l information to you. Examples of information include test results, appointment reminders and other information of a clinical nature.

Please check one:

____ *DO NOT leave any medical information on my answering machine or voice mail.*

____ *I give permission to Wilson Dermatology & Skin Care to leave medical information on my answering machine or voice mail.*

You may also designate two additional people with whom we may discuss your medical information with.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Financial Assignment and Release:

I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for all non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

_____ Date: ____/____/_____
Signature

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IMPORTANT OFFICE POLICIES

Notice regarding HMO Insurances:

Please be advised that an HMO plan requires you to have a referral that is active for the date of service received. Although we strive to check each patient (insurance) file, it is ultimately the Patient's Responsibility to have an active referral from their primary care physician.

If any date of service is not covered by an active referral, you will be billed directly and will be responsible for the charges. As a courtesy, we are reminding you of the policy that is set forth by insurance companies to have this referral.

Notice regarding Medicaid Insurance:

Wilson Dermatology & Skin Care participates in most commercial insurance, we **DO NOT** participate with any Medicaid Insurance. **YOU WILL BE RESPONSIBLE FOR THE BALANCE.**

Cancellation/No Show Policy

Please be aware that we will charge a fee of $25.00 for each appointment that is canceled less than 24 hours in advance or for No Shows on the scheduled appointment. We try our utmost to provide short wait times and to accommodate patients with available appointment times. Due to this increasing occurrence, we are forced to discourage last minute cancellations and no shows for the appointment.

By signing below you acknowledge you are aware of the above listed office policies and understand you will be held liable for any violation of the above policies. Thank you for your coopertation.

_____
Name (Print)

_____ Date: ____/____/_____
Signature

If patient is a minor, printed name and signature of parent/guardian:

_____
Name

_____
Signature

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Thyroid Problems
Hyper - Hypo
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

NONE

Other _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer

NONE

Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____

Medications: (Please enter all current medications)

_____

_____

_____

Drug Allergies: (Please enter all allergies)

_____

_____

_____

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never smoked
Former Smoker

ALERTS: (please circle all that apply)

Blood thinners
Defibrillator
Pacemaker
Are you pregnant or currently trying to get pregnant?

Other_____

Family History of Skin Cancer, Eczema, Psoriasis or Acne (Only first degree relatives)

_____

_____

_____

_____

Preferred Language: _____

Race:_____

***Ethnic Group <u>CIRCLE ONE</u> (hispanic or non-hispanic)** (Obama Care Mandated)

Preferred pharmacy Name: _____

Phone#: _____

City or Zip code:_____

Referring Doctor: _____