Westmoreland Dermatology & Surgery Center

Patient Information

Patient's Legal Name: (First, Middle, Last)

SSN: **Date of Birth:**

Marital Status: ⁄⁄Divorced ⁄⁄Married ⁄⁄ Single ⁄⁄Minor

Gender: ⁄⁄Male ⁄⁄Female

Language:
⁄⁄English
⁄⁄Other:_____

Ethnicity:
⁄⁄Hispanic/Latino
⁄⁄Non Hispanic/Latino

Race:
⁄⁄Caucasian/White
⁄⁄Black/African American
⁄⁄Native Hawaiian/Other Pacific Islander
⁄⁄Asian
⁄⁄Other

Mailing Address (PO Box, City, State, Zip)

*****Required*****
Street Address (Street, City, State, Zip)

Home Phone: **Cell Phone:** **Work Phone:**

Email Address:

⁄⁄ Yes, I would like to receive information, i.e., skin care information, specials, and upcoming events from Westmoreland Dermatology & Surgery Center and the CosMediCenter via email.

⁄⁄ No, I would not like to receive information via email.

Insurance Information Complete this information if the patient is covered under another individual's insurance plan

Name of Insured/Subscriber:

SSN: **Date of Birth:** **Relationship to Patient:**

Mailing Address (PO Box, City, State, Zip)

*****Required*****
Street Address (Street, City, State, Zip)

Home Phone: **Cell Phone:** **Work Phone:**

Guarantor Information Complete this information if the patient is under 21*****Required*****

Name of Parent/Legal Guardian:

SSN: **Date of Birth:** **Relationship to Patient:**

Mailing Address (PO Box, City, State, Zip)

*****Required*****
Street Address (Street, City, State, Zip)

Home Phone: **Cell Phone:** **Work Phone:**

Westmoreland Dermatology and Surgery Center
Consent for Treatment

Chart #

As a patient, I hereby consent to the usual medical services while at Westmoreland Dermatology and Surgery Center.

Medicare and/or Medicaid: I hereby request that payment of authorized Medicare/Medicaid benefits to or on my behalf for services furnished in or by Westmoreland Dermatology, shall be made to the clinic and I specifically assign such benefits to the clinic. I hereby certify that all information given by me in connection with applying for benefits under Title XVIII of the Social Security Act is true, correct and complete in all respects. I understand that payment for certain services not deemed medically necessary are not authorized under the Medicare/Medicaid Program and I shall be responsible for the entire charges incurred unless other third party coverage is available.

Insurance: I hereby assign Westmoreland Dermatology and Surgery Center all rights, benefits, and interest under any insurance policy, health plan, or third party payer liable to me, in consideration for services rendered by the physician. I hereby authorize payment to Westmoreland Dermatology and Surgery Center by any insurance policy, health plan or third party payer for treatment received at the clinic. Secondary third payer insurance claims will not be filed by Westmoreland Dermatology and Surgery Center; however, we will provide you with the information needed for you to file and be reimbursed.

Financial Responsibility: I understand that I am financially responsible to the clinic for all charges not covered or paid by insurance. I also understand that my insurance will be filed as a courtesy, but I am financially responsible for any charges incurred at Westmoreland Dermatology and Surgery Center. I also understand and agree that all deductibles, coinsurance, non-covered charges, and other items not paid by insurance, health plan or other third party payers are due and payable at time of service. We do verify benefits prior to your visit and do our best to provide and accurate estimate of "your portion" of the charges incurred that day. Charges remaining on an account after thirty days become the patient's responsibility. I also agree that in the case of default of payment, if this account is placed in the hands of a collection agency or attorney for collection or suit, all collection fees, finance charges, attorney fees, costs and other expenses will be paid by me. I understand that in certain circumstances, specimens may be sent to an outside facility for diagnostic purposes. I understand that I am responsible for any charges incurred.

Non-Certification: I hereby agree that as the policyholder/beneficiary of insurance, health plan or other third party payer, I am responsible for assuring certification is obtained from the insurance company, third party administrator or health plan for the procedure date. If certification is not obtained, I further agree that in the event the insurance health plan or other third party payer denies either all or part of the payment on the account, I will pay the account in full upon demand from the clinic.

Consent for Release of Health Information for Billing and Payment Purposes: I consent to the release of my health information (medical records, medical results, and any and all other health information) by the clinic or any physician involved in my care for the purpose of billing, claims management, medical data processing, reimbursement, certification to any insurance company, third party payer, health plan or government agency which are necessary for the billing and payment of my account.

Photographs: I hereby give permission for the physicians of Westmoreland Dermatology or any assistant they may designate to take pictures for diagnostic purposes or for enhancement of the medical record.

New Regulations: State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this notice. This notice will take effect on April 14, 2003 and will remain in effect until it is amended or replaced by us. It is our right to change our privacy practices provided the law permits the changes. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and or received by us before the date changes were made.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. Health information about you may be disclosed to your family, friends, and/or other persons you choose to involve in your care. You may request a form to sign that prohibits anyone other than yourself having access to your health information.

Appointment Time _____

_____

Signature of Patient or Guardian Date

Westmoreland Dermatology & Surgery Center

Notice of Privacy Practices/Written Acknowledgement Form

I have reviewed a copy of Westmoreland Dermatology and Surgery Center's Notice of Privacy Policies.

_____

Signature of Patient Date

Treatment to Minors

This form must be completed if the patient is under the age of 21.

Many times parents find themselves unable to accompany their minor child to appointments. We require that this form be completed to insure that your child can receive medical treatment without your presence.

I authorize my child, _____, to receive medical treatment at Westmoreland Dermatology & Surgery Center.

I agree to pay any charges incurred. Our offices require payment at time of service and we accept all major credit cards. If your child is unaccompanied, please send one of these forms of payment.

_____

Signature of Parent/Legal Guardian Date

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: ___/___/___

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examinations rendered to me and claims information. This information may be released to:

***** PLEASE FILL IN BLANKS WITH NAMES *****

[ ] Spouse: _____

[ ] Child(ren): _____

[ ] Other: _____

[ ] Any health care provider or facility: _____

[ ] Ok to leave a message: _____

This Release of Information will remain in effect until terminated by me in writing.

Signed: _____ Date: ___/___/___

Medical History

*****Please provide your nurse with this medical history form when called back for your evaluation.*****

Terry Westmoreland, M.D.
Misty Sharp, M.D.
Paula Atkins, FNP-BC
Celia Kidder, FNP-C

Patient Name_____

Date of Birth _____

Today's Date _____

NEW PATIENT – YES OR NO (PLEASE CIRCLE)

What is the primary reason for your visit today?_____

Primary Care Physician_____

Did a Physician's office schedule this appointment for you or refer you to this office? YES NO

If yes, Physician's Name_____

FEMALE PATIENTS ONLY: Are you currently pregnant or could be pregnant? YES NO
Are you currently breastfeeding? YES NO

CURRENT MEDICATIONS (*Please list, including over the counter medicines, vitamins & herbs*)

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

Over The Counter Medications _____

_____

Pharmacy_____

DRUG ALLERGIES
Name of Drug & type of reaction

1._____

2._____

3._____

4._____

PAST SURGERIES
Surgery When?

1._____

2._____

3._____

4._____

PAST MEDICAL HISTORY *PLEASE CHECK THE PROBLEMS YOU HAVE HAD*

_____Allergies (seasonal)
_____Anemia
_____Arthritis
_____Artificial Heart Valve
_____Artificial Joints
_____Asthma
_____Bleeding / Blood Disorder
_____Cancer Type ? _____
_____Congestive Heart Failure
_____COPD / Emphysema
_____Depression
_____Diabetes
_____Drug Abuse /Addiction
_____Eczema
_____Fever Blisters
_____Gallbladder Disease
_____Gastrointestinal Disease
_____Glaucoma
_____Gout
_____Hearing Impairment
_____Heart Attack / Stents
_____Heart Murmur
_____Heart Surgery / Disease
_____Hepatitis
_____High Blood Pressure
_____High Cholesterol
_____HIV/AIDS
_____Joint Surgery
_____Keloids
_____Kidney Problems / Stones
_____Lupus/Auto-immune Disease
_____Menstrual Dysfunction
_____Migraine Headaches
___ Mitral Valve Prolapse
_____Osteoporosis
_____Psychiatric Condition
_____Prostate Problems
_____Psoriasis
_____Rosacea
_____Seizure Disorder
_____Stroke
_____Thyroid Disease
_____ Vascular Disease
____Vision Impairment

Do you have any disease, condition or problem not listed? If so, please describe:

_____

_____

Do you have a history of skin cancer? YES NO

If so, what type and location (*example:. Squamous on the neck*) _____

How and where was it treated? _____

Do you smoke? YES NO Former Smoker? What year did you quit? _____
If you marked yes, are you interested in information about quitting? YES NO

Do you use alcohol? YES NO If yes, how often? Daily, Weekly, Monthly

Do you have a pacemaker? YES NO If so when? _____

Did you receive the flu vaccine between October1 – March 31? YES NO

If you are over the age of 65, have you had the pneumonia vaccine? YES NO

Do you have a living will (Advanced Care Plan) YES NO

FAMILY HISTORY (*Please circle*)
Is there a family history of skin cancer? YES NO Type_____
Is there a family history of melanoma? YES NO Type_____
Is there a family history of any skin disorder? YES NO Type_____
Is there a family history of - cancer, diabetes, high blood pressure, heart disease? (Please Circle all that apply)
If I have a change of health, I will inform my physician of this at my next appointment.

_____ ____/____/____
Signature of Patient Date
(Parent or Guardian if Child or Minor)

Terry Westmoreland, M.D.
Misty Sharp, M.D.
Paula Atkins, FNP-BC
Celia Kidder, FNP-C

OFFICE USE ONLY

(Not necessary for patient to fill out)

Height_____ Weight_____ BP_____ Pulse _____