



PATIENT INFORMATION

Patient Name: _____

Date: _____

Date of Birth: _____

Age: _____

Male

Female

Address: _____

City: _____

State: _____

Zip: _____

Home Phone: (_____) _____

Cell Phone: (_____) _____

Social Security #: _____

Drivers License #: _____

Employer: _____

Occupation: _____

Work Phone: (_____) _____

Do you authorize email communication with our clinic pertaining to appointment reminders, specials, events, etc.? Yes No

Email Address: _____

BILLING CONTACT

Name: _____

Relationship to Patient: _____

Address: _____

Phone: (_____) _____

EMERGENCY CONTACT

Name: _____

Relationship to Patient: _____

Address: _____

Phone: (_____) _____

INSURANCE INFORMATION *(In order for us to file a claim on your behalf, this section must be completed in its entirety.)*

Insurance Name: _____

Phone: (_____) _____

Claims Address: _____

City: _____

State: _____

Zip: _____

ID #: _____

Medicare # (if applicable): _____

Group / Account #: _____

Subscriber Name: _____

Subscriber's Date of Birth: _____

Relationship to Patient: _____

Subscriber's Social Security #: _____

Do you have secondary insurance? Yes No

HOW DID YOU HEAR ABOUT WESTLAKE DERMATOLOGY & COSMETIC SURGERY?

Doctor: _____

Friend: _____

Insurance

Internet / Website

Radio Ad (which station?): _____

Billboard

Magazine Ad (which one?): _____

Other: _____



GENERAL HEALTH HISTORY

Patient Name: _____

Date: _____

Reason(s) for Today's Visit: _____

Would you like to have a full-body skin exam performed? Yes No If yes, when? Today (time permitting) Next Visit

Are you allergic to any medications? Yes No If yes, please specify: _____

Have you ever had dental anesthesia (Novocaine)? Yes No If yes, any bad reaction? Yes No

When taking antibiotics, do you experience: Nausea, vomiting or diarrhea? Yes No Yeast Infection? Yes No

Current Medications (include prescriptions, over-the-counter meds, vitamins, and herbals): _____

Preferred Pharmacy Name and Location: _____

PATIENT MEDICAL HISTORY

Do you have now, or have you ever had diseases or conditions of (please circle yes or no):

Skin Cancer	Yes	No	Thyroid Problems	Yes	No
Other Skin Disease	Yes	No	Asthma / Wheezing	Yes	No
Problems with Skin Healing	Yes	No	Chest Pain	Yes	No
Keloids (Scars) after Surgery	Yes	No	Heart Attack	Yes	No
Skin Rash / Medications	Yes	No	Heart Murmur	Yes	No
Skin Rash / Environment	Yes	No	Irregular Heartbeat	Yes	No
Skin Rash / Bandages	Yes	No	Pacemaker	Yes	No
Skin Rash / Topical Neosporin	Yes	No	Phlebitis	Yes	No
Skin Rash / Food	Yes	No	Blood Clots	Yes	No
Skin Rash / Other	Yes	No	Kidney Disease	Yes	No
Bleeding Problems	Yes	No	Liver Disease	Yes	No
Swelling Hands / Feet	Yes	No	Lung Disease	Yes	No
Diabetes	Yes	No	Gastrointestinal Disorder	Yes	No
High Blood Pressure	Yes	No	Arthritis / Joint Deformity	Yes	No
Dizzy Spells	Yes	No	Convulsions / Epilepsy / Seizures	Yes	No
Eye Disease	Yes	No	Fainting	Yes	No

If yes on any of the above, please explain: _____

List any other disease or condition: _____

Surgeries in the past 6 months: _____

SOCIAL HISTORY

Do you smoke? Yes No If yes, how much? _____

Do you drink alcohol? Yes No If yes, how much? _____

Have you had or have you been exposed to HIV (AIDS) or Hepatitis? Yes No

FAMILY MEDICAL HISTORY

If yes...

Skin Cancer Yes No Relation: _____ Type of Cancer: _____

Other Medical Problems Yes No Relation: _____ Type of Problem: _____

FEMALE PATIENTS ONLY

Currently pregnant? Yes No Using contraceptives? Yes No

Breastfeeding? Yes No Trying to conceive? Yes No



ACKNOWLEDGEMENT / CONSENT

____ (initial) **RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, (print patient name) _____, have read a copy of Westlake Dermatology & Cosmetic Surgery's *Notice of Privacy Practices*. (This document is available at our front desk or westlakedermatology.com.)

____ (initial) **CANCELLATION POLICY**

If the patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel within 24 hours of the scheduled appointment. **Westlake Dermatology & Cosmetic Surgery reserves the right to charge the patient a \$50 fee if the patient does not cancel the appointment within 24 hours.**

____ (initial) **RELEASE OF MEDICAL INFORMATION**

I **do / do not** (circle one) authorize Westlake Dermatology and its designated representatives to release medical information to my spouse, parent or guardian.

I **do / do not** (circle one) authorize Westlake Dermatology and its designated representatives to release medical information to my primary care physician. If authorized, please provide name of physician: _____

____ (initial) **CONTACT PERMISSION**

In the event that Westlake Dermatology & Cosmetic Surgery needs to contact you (patient) regarding an appointment, lab result, medication, or any other reason, it is permissible to:

Check all that apply:

- Leave a message on an answering machine.
- Speak with spouse / significant other.
- Speak with other family members.

____ (initial) **CONSENT TO TREATMENT**

I consent to the performance of those diagnostic procedures, examinations, and rendering of treatment by the medical provider and their designated medical office staff as is deemed necessary in the medical provider's judgement.

____ (initial) **AUTHORIZATION / ASSIGNMENT / FINANCIAL RESPONSIBILITY**

I authorize the release of any medical information necessary to process an insurance claim on my behalf. I understand that I am financially responsible for all charges and that I am responsible for obtaining any referrals required by my insurance carrier. I request that my medical insurance carrier make any payment directly to Westlake Dermatology & Cosmetic Surgery for services rendered to me. As a courtesy, my charges will be filed with my insurance carrier; however, I will be billed if the claim is denied or is not paid in a timely manner. Should my account become a collection problem, additional charges may be incurred.

My signature below indicates that I have read and am in agreement with all statements that I have initialed above.

Signature of Patient (or guardian)

Date