

Medicare Patient Information

Name: _____
Date of Birth : ____/____/____ Age ____ Sex: Female Male Marital Status: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (_____) _____ Work/Cell Phone: (_____) _____
Social Security #: _____ Email: _____
Name of Primary Care Physician: _____
How did you hear about us? _____

YES NO

- Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?
- Are you covered by a HMO/PPO which makes Medicare secondary?
- Are you coming to this office for an illness or accident that has been covered or is authorized for coverage from the VA (Veteran's Administration)?
- Are you eligible for any benefits under the Federal Black Lung Program?
- Are you coming to this office for an illness, accident or injury that is the result of an automobile accident?
- Are you coming to this office due to Medicare disability coverage?
- Are you covered by the Federal End Stage Renal Disease Program?
- Are you presently receiving Workers' Compensation?
- Is the illness or injury you are coming to this office for the result of work-related causes?
- Do you have medical assistance through Welfare or Stat-aid?

If you answered YES at ANY of the above questions: _____ Name of Company

Policy Number _____ Group Number _____

Name of Spouse of Close Relative or Friend _____ Phone# (_____) _____
(In Case of Emergency)

Name as it appears on your Medicare card _____
(Please Print)

Medicare Health Insurance Claim Number as it appears on your card _____
(This is usually your social security number. Be sure to include the letter after the nine digit number. It is important that we have both number and letter.)

Please sign so we may have your Medicare authorization on file:

I authorize any holder of medical or other information about me to release 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.

Date _____ Signature _____

We request secondary insurance information for our records (supplemental Medicare Insurance info.) Please fill out below if you are covered by a plan which covers the 20% NOT covered by Medicare. (Medigap Coverage)

Name of Insurance Company _____

Policy Number _____ **Group Number** _____

Please sign so we may have your Supplemental authorization on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

If it becomes necessary to turn your account over to a collection agency for unpaid co-payment deductibles or non Medicare coverage, a 28% collection fee will be added to the unpaid balance. Your signature below indicates your understanding of this policy.

Date _____ Signature _____

Referred by Dr. _____

Medical History

Patient: _____ Date: _____

Reason for today's visit: _____

Are you allergic to any medications? YES NO if yes, list:

1. _____ 2. _____

List all Medications you are currently taking:

1. _____ 3. _____
2. _____ 4. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

	YES	NO		YES	NO
Lungs:			Other Systemic:		
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Stomach	<input type="checkbox"/>	<input type="checkbox"/>
			Bowel	<input type="checkbox"/>	<input type="checkbox"/>
Vascular:			Hepatitis or		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Skin	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy		
Irregular HeartBeat	<input type="checkbox"/>	<input type="checkbox"/>	or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>			

Do you drink alcohol? YES NO If YES _____ drinks per day

Do you use IV drugs? YES NO If YES what? _____ How much? _____

Have you had or have you been exposed to HIV (AIDS) ? YES NO

Have you ever had dental anesthesia (Novacaine)? YES NO Any bad reaction? YES NO

Skin:

When you are exposed to sun do you: Tan only Tan and burn Burn

Have you ever had skin cancer? YES NO

Has anyone in your family had skin cancer? YES NO If Yes, Who? _____

Do you have a history of any specific skin diseases? YES NO

If yes, please list: _____

List any other disease or condition we should know about: _____

List surgical procedures you have had in the last 6 months: _____

Please answer the following questions:

A. Do you smoke? YES NO If yes, how much:

B. Do you bleed easily? YES NO

C. (Women) Are you pregnant? YES NO Due Date: _____

D. Do you have artificial joint(s) ? YES NO

E. What is your occupation ? _____

F. What are your hobbies? _____

Completed by: Patient
 Medical Assistant _____
Initials

Signed by Physician _____ Date _____

Reviewed by _____ Date _____

DERMATOLOGY CENTRE

PLEASE READ AND SIGN BELOW SO WE CAN UPDATE YOUR FILE

I GIVE PERMISSION TO DR. JAMES R. WATT AND HIS MEDICAL STAFF TO DISCUSS MY
CONDITION WITH MY FAMILY MEMBERS OR OTHER PERSONS SPECIFIED, UNLESS
NOTIFIED OTHERWISE IN WRITING. PLEASE SPECIFY ANY OTHER ADDITIONAL PERSON(S)
THAT YOU MAY WANT ME TO CORRESPOND WITH:

PATIENT'S NAME (PLEASE PRINT)

X

PATIENT'S SIGNATURE

X

DATE

* If you do not wish to name anyone
Please Put "None" and Sign.

DERMATOLOGY CENTRE

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I _____, HAVE RECEIVED A COPY OF THE
DERMATOLOGY CENTRE NOTICE OF PRIVACY PRACTICES.

~~X~~ _____
SIGNATURE OF PATIENT

~~X~~ _____
DATE

* Please Review or Download form "Privacy -
Practices" or Pick up at Check in Counter
on wall.



JAMES R. WATT, D.O., F.A.A.D.
Dermatology & Dermatologic Surgery
Diplomate, American Board of Dermatology
Fellow, American Academy of Dermatology

Appointment /Cancellation /No Show Policy

Appointments

Office visits are by appointment only please call (352)341-3344. The front desk may ask about the reason for your visit. This helps us to schedule the doctors time more efficiently. If you would like to arrive 15 minutes prior to your appointment time you may do so. There are times when we may be ahead of schedule and we may be able to take you early but this *should not* be expected. Patients who are late for any appointment may be asked to reschedule at the front desk/physician's discretion. Please do not argue with our staff on this matter.

Cancellations

We would like to thank you for being a patient in our office. We value all of our patients and strive to provide the best possible care in a comfortable setting. Please understand that when we schedule your appointment, we are reserving time for your particular needs. We kindly ask that if you must cancel/change your appointment, please give us at least a 24 hour notice. This courtesy makes it possible to give your reserved time to another patient. When appointments are made, charts are pulled, records requested, a room is prepped and sometimes instruments prepared. Our time is as valuable as yours.

Missed Appointments (Non Cancelled)

We understand that occasional missed appointments can occur for a variety of reasons. When you miss an appointment without canceling, some one else who could have been seen in your place is delayed unnecessarily. We track missed(non cancelled) appointments. A "No Show/Day Of Appointment Cancellation" is defined as a missed appointment without a 24 hour notice. There will be a **\$25.00 charge** for a missed or non cancelled appointment. Repeat missed appointments may result in discharging you from the practice.

Payment

Payment is due in full at the time of service...no exceptions.

_____ X _____
Patient Name Signature Date