PATIENT INFORMATION FORM FOR WATT DERMATOLOGY

PATIENT NAME: _____ **DATE**: _____

DOB: _____ AGE: _____ SEX: _____ RACE: _____ HISPANIC/LATINO? Y OR N

ADDRESS: _____
STREET CITY STATE ZIP

HOME PH: _____ **CELL PH**: _____ **WORK PH**: _____

EMAIL: _____ **SS#**: _____

REFERRED BY: _____ PH:_____

MARTIAL STATUS: _____ OCCUPATION: _____ HOBBIES: _____

PRIMARY CARE PHYSICIAN: _____ PH: _____

*Pharmacy of choice: _____ Location: _____ PH#: _____

PARENT OR RESPONSIBLE PARTY (*IF DIFFERENT FROM PATIENT*)

NAME: _____ PH: _____

ADDRESS: _____ DOB: _____ SS#: _____

1: PRIMARY INSURANCE NAME: _____ POLICY TYPE: [ ] HMO [ ] PPO
POLICY/MEMBER #: _____ **GROUP**: _____
NAME POLICY HOLDER: _____ DOB: _____ SS#: _____
RELATIONSHIP: [ ] SELF [ ] MOTHER [ ] FATHER [ ] OTHER: _____

2: SECONDARY INSURANCE NAME: _____ POLICY TYPE: [ ] HMO [ ] PPO
POLICY/MEMBER #: _____ **GROUP**: _____
NAME POLICY HOLDER: _____ DOB: _____ SS#: _____
RELATIONSHIP: [ ] SELF [ ] MOTHER [ ] FATHER [ ] OTHER: _____

EMERGENCY CONTACT: _____ PH:_____

PLEASE ATTACH A COPY OF THE PATIENTS INSURANCE CARD (BOTH SIDES)

MEDICAL HISTORY & MEDICATION FORM

PATIENT NAME: _____ **DATE:** _____

List any Allergies: 1. _____ **2.** _____

List any Medications or provide List: 1. _____

2. _____ 3. _____

4. _____ 5. _____

CHIEF COMPLAINT (Reason for visit): _____

PAST SKIN HISTORY

Condition	Yes	No	Comments	Condition	Yes	No	Comments
No Significant History				Malignant Melanoma			
Acne				Nail Disease			
Actinic Keratosis				Photosensitivity			
Basal Cell Carcinoma				Psoriasis			
Contact Dermatitis				Rosacea			
Dysplastic Nevus				Squamous Cell Carcinoma			
Eczema / Dermatitis				Urticarial (Hives)			
Hair Loss				Vitiligo			
History of Sunburns				Xerosis (Dry Skin)			
Lupus				Other: _____			

When exposed to the sun, do you: [ ] Tan / [ ] Tan and Burn / [ ] Burn

PAST MEDICAL HISTORY

Condition	Yes	No	Family	Condition	Yes	No	Family
No Significant History				Abnormal Bleeding			
Bleeding Disorder				Adopted			
Cancer (non-skin)				Autoimmune Disorders			
Hepatitis/HIV/TB				Arthritis / Joint			
Diabetes				Kidney Disease			
Gastro / Ulcers				Seizures			
Heart Disease				Pacemaker			
High Blood Pressure				Hepatitis			
Liver Disease				Skin Disease			
Thyroid Disease				Fainting			

List any Previous Surgeries: _____

SOCIAL & GENERAL HEALTH

Question	Yes	No	Details / How Much?
Do you smoke?			
Are you Pregnant?			
Do you Drink Alcohol?			
Do you use Recreational Drugs?			
Do you Bleed easily?			
Do you have Artificial Joints?			

DERMATOLOGY CENTRES, P.A.

WATT DERMATOLOGY

HIPAA FORM

I GIVE PERMISSION TO DR. JAMES WATT AND HIS MEDICAL STAFF TO DISCUSS MY CONDITION WITH MY FAMILY MEMBERS LISTED BELOW;

1: _____

2: _____

3: _____

- WE WILL USE YOUR HEALTH INFORMATION FOR REFERRALS, TREATMENT, FILING CLAIMS WITH YOUR INSURANCE PROVIDER, EMERGENCIES, IF IT IS REQUIRED BY LAW, LEGAL PROCEEDINGS, LAW ENFORCEMENT, GOVERNMENT, PUBLIC SAFETY, MILITARY, WORKER'S COMPENSATION, AND RESEARCH IF REQUESTED.

*MAY WE LEAVE A DETAILED MESSAGE REGARDING YOUR HEALTH, TEST RESULTS, OR AN UPCOMING APPOINTMENT ON YOUR VOICEMAIL OR IN EMAIL? YES, _____ OR NO, _____

*IF YOU WOULD LIKE A COPY OF THE PRIVACY PRACTICES NOTICE, PLEASE ASK THE FRONT DESK FOR A COPY.

[ ] ACKLOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES.

PATIENT'S NAME: _____

PATIENT'S SIGNATURE (PARENT): _____

DATE: _____

OFFICE POLICIES FOR WATT DERMATOLOGY

*I AUTHROIZE 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 MEDICAL BENEFITS TO THE PHYSICIAN.

*I UNDERSTAND THIS OFFICE DOES NOT TAKE HMO'S WITHOUT PRIOR AUTHORIZATION AND ANYTHING NOT COVERED IS MY FULL RESPONSIBILITY. I UNDERSTAND THAT IF MY INSURANCE IS OUT OF NETWORK (ANYTHING BESIDES MEDICARE AND BLUE CROSS BLUE SHIELD), I AM FULLY RESPONSIBLE TO MAKE SURE I HAVE COVERAGE FOR THE VISIT. I UNDERSTAND MY CO-PAY OR DEDUCTIBLE CAN BE HIGHER AND WILL BE COLLECTED/BILLED ACCORDINGLY. KEEP IN MIND SOME INSURANCES DO NOT COVER OUT OF NETWORK (NON-CONTRACT) PROVIDERS AND YOU UNDERSTAND IT WILL BE FULLY YOUR FINANCIAL RESPONSIBILITY. IT IS THE PATIENT'S RESPONSIBILTY TO VERIFY INSURANCE COVERAGE AND BENEFITS.

*I UNDERSTAND PAYMENT IS REQUIRED FOR ALL SERVICES AT THE TIME THEY ARE RENDERED, UNLESS OTHERWISE COVERED BY YOUR INSURANCE PLAN. FOR THOSE PATIENTS, INSURANCE IS PREVERIFIED AND A COPAY OR SELF PAY CHARGE WILL BE COLLECTED. I UNDERSTAND I MAY RECEIVE A BILL FOR ANY UNCOVERED CHARGES MY INSURANCE DEEMS IS MY RESPONSIBILTY AND WILL PAY IN A TIMELY MANNER. I UNDERSTAND THAT IF PAYMENT IS NOT RECIEVED WITHIN 90 DAYS, MY ACCOUNT WILL BE TURNED OVER TO COLLECTIONS WHICH APPLIES A 28% CHARGE TO THE BILL. FAILURE TO PAY YOUR PORTION OF INSURANCE ALLOWABLE IS A VIOLATION OF YOUR INSURANCE CONTRACT AND MAY RESULT IN INSURANCE CANCELLATION. YOUR SIGNATURE BELOW SIGNIFIES YOUR UNDERSTANDING AND WILLINGNESS TO COMPLY WITH OUR POLICY.

*I UNDERSTAND THAT OFFICE VISITS ARE BY APPOINTMENT ONLY, AND THAT IF I ARRIVE EARLY TO MY APPOINTMENT I STILL MAY NOT BE SEEN TILL MY APPOINTMENT TIME. I UNDERSTAND THAT IF I AM ANY MORE THAN 5 MINUTES LATE, I MAY BE ASKED TO RESCHEDULE AT THE FRONT DESK/DR. WATT'S DISCRETION. PLEASE DO NOT ARGUE WITH OUR STAFF. I UNDERSTAND THAT A **24 HOUR NOTICE** IS REQUIRED FOR ANY CANCELLATIONS OR RESCEDULES AND IF I FAIL TO DUE SO, OR NO SHOW AN APPOINTMENT, **A $25 FEE** WILL BE CHARGED TO MY ACCOUNT.

***BILLING PREFERENCE: [ ] TEXT [ ] EMAIL [ ] PAPER**

CELL PHONE/ EMAIL/ ADDRESS: _____

*BY SIGNING ON THIS LINE I UNDERSTAND THAT IF I CHOOSE TEXT OR EMAIL, I WILL ONLY GET A LINK TO PAY MY BILL, WITHOUT ANY DETAILED INFORMATION ATTACHED. I MAY RECIEVE A DETAILED PAPER STATEMENT AT ANYTIME BY COMING TO THE OFFICE TO PICK ONE UP.

SIGNATURE: _____ DATE: _____