WONDERLICH DERMATOLOGY

## PATIENT'S PERSONAL INFORMATION

First Name_____ Last Name _____ Middle Initial_____

Mailing Address_____ Apt #_____

City_____ State_____ Zip_____

Date of Birth_____ /_____ / _____ Social Security # _____ - _____ - _____ Driver's License #_____

Phone # _____
CELL HOME WORK

E-Mail_____

Preferred Pharmacy_____

Gender ❑ Male ❑ Female

## PHOTOGRAPHY

May we include photographs of you in your electronic medical record? These are for patient care purposes only and stored only in the electronic medical record. There is a separate consent form for all other photography/videography uses.

❑ Yes, I consent to photographs in my electronic medical record. ❑ No, I decline photographs at this time.

## EMPLOYMENT

Employer Name _____ Phone_____

Address_____ Occupation_____

## EMERGENCY CONTACT

Name _____ Relationship _____Phone_____

## PRIMARY CARE PHYSICIAN

Doctor Name_____ Did This Doctor Refer You To Us? ❑ Yes ❑ No

When was your last visit with this provider_____ What clinic?_____

(Please note that you must have a referral from your primary care provider to see us if you are covered under Medicare or Medicaid. Exceptions can be made on a case by case basis if you have been seen by primary care within the past calendar year.)

If you were not referred by your doctor, how did you hear about us?

❑ Direct Mail ❑ Event ❑ Newsminer ❑ Facebook ❑ Instagram ❑ Pinterest ❑ Four Square ❑ Friend ❑ Word of Mouth ❑ Google ❑ Hospital ❑ Insurance Company ❑ Radio ❑ The View Magazine ❑ Twitter ❑ Website ❑ Yellow Pages ❑ Real Self ❑ New Beauty ❑ Other_____



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WONDERLICH DERMATOLOGY

## PERSON RESPONSIBLE FOR BILL

❑ Self

❑ Other: Name _____ Relationship _____

Mailing Address_____ Apt #_____

City_____ State_____ Zip_____

Date of Birth_____ /_____ /_____ Phone #_____
HOME CELL WORK

## PRIMARY MEDICAL INSURANCE

Insurance Company_____Employer_____

Policy Number_____ Group Number_____

Policy Holder's Name *(if different form patient)*_____ Date of Birth *(Required)* ____ /____ /____ SSN ____-____-____

Relationship to Patient ❑ Self ❑ Spouse ❑ Child ❑ Other_____

## SECONDARY MEDICAL INSURANCE

Insurance Company_____Employer_____

Policy Number_____ Group Number_____

Policy Holder's Name *(if different form patient)*_____ Date of Birth *(Required)* ____ /____ /____ SSN ____-____-____

Relationship to Patient ❑ Self ❑ Spouse ❑ Child ❑ Other_____

## PHARMACY IMPORT CONSENT

We may be able to import your medications from SureScripts, which is an electronic database used by most pharmacies. This often improves the accuracy of your medication list in our records. Do we have your permission to upload this information?

❑ Yes, Dr. Kimberly Wonderlich and her staff may import my medication history

❑ No, I decline to have my prescription information imported

## RELEASE OF INFORMATION

Other than yourself, with whom may we discuss your medical information? *(Please give the persons' name and relationship to you.)*

_____



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# OFFICE FINANCIAL POLICY

Patient Printed Name_____Date of Birth_____

Please Initial:

_____Wonderlich Dermatology appreciates the confidence you have shown in choosing us to provide for your health care needs. The services you have elected to participate in imply a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. If you have insurance, please keep in mind that your insurance is a contract between you and your insurance company. As a courtesy we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill and our office cannot guarantee that your carrier will pay your claim.

_____You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. Payment is due at the time service is rendered, unless other arrangements have been made prior to the services being rendered. This includes Co-Pays. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period you will be responsible for your balance in full. Our office will not enter into a dispute with the insurance carrier over a claim. We will be happy to assist wherever possible. If an insurance payment is mistakenly sent to the patient, instead of the office for service rendered, the patient is expected to provide payment with 10 days of receipt along with the Explanation of Medical Benefit.

_____**LATE CANCELLATION AND NO SHOW POLICY:**
**--A "late cancellation" is canceling an appointment without calling with a 24 hour notice for an office visit and a 48 hour notice for a procedure. A "no show" is missing a scheduled appointment.**
**--A charge of $50.00 will be assessed for each late cancellation or no show for an office visit if less then 24 hours notice is given.**
**--A charge of $50.00 will be assessed for each late cancellation or no show of a procedure appointment if less then 48 hours notice is given.**

_____I have read the above policies regarding my financial responsibilities to Wonderlich Dermatology for providing a medical service to me or above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Wonderlich Dermatology, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

_____I agree to pay any costs incurred by Wonderlich Dermatology in collecting any amount due including, without limitations, collection agency fees and attorney's fees.

Printed Name_____
PATIENT OR REPRESENTATIVE

Signature_____Date_____

## SELF-PAY POLICY

I do not have health insurance and will be responsible for services rendered here at Wonderlich Dermatology. I agree to pay the practice the full and entire amount of treatment given to me or to the above named patient at each visit. I am aware that there may be an additional balance due once the full charges are assessed.

Printed Name_____
PATIENT OR REPRESENTATIVE

Signature_____Date_____



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# HIPAA PATIENT CONSENT FORM

Patient Printed Name_____Date of Birth_____

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent

## THIS CONSENT WAS SIGNED BY

Printed Name_____
PATIENT OR REPRESENTATIVE

Signature_____ Date_____

Relationship to Patient_____
IF OTHER THAN PATIENT

## WITNESS

Printed Name_____
PRACTICE REPRESENTATIVE

Signature_____ Date_____



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WONDERLICH DERMATOLOGY

# MEDICAL HISTORY

Patient Printed Name_____Date of Birth_____

## REASON FOR VISIT

Please list the skin issue you would like to have addressed at this visit:

Skin Issue to be addressed:

Concern :_____

Duration:_____

Where on body:_____

Past treatments:_____

## PAST MEDICAL HISTORY

Please list any active medical conditions or significant past medical diagnoses.

_____

_____

_____

_____

_____

_____

_____

❑ None

## PAST SURGICAL HISTORY

Please list any major surgeries you have had in the past. Please include skin cancer surgeries.

_____

_____

_____

_____

❑ None

## SKIN DISEASE HISTORY

Please check all that apply. All unchecked boxes will be interpreted as "no" or "does not apply."

❑ Acne
❑ Actinic Keratoses
❑ Basal Cell Cancer
❑ Blistering Sunburns
❑ Dry Skin
❑ Eczema
❑ Flaking or Itchy Scalp
❑ Melanoma
❑ Precancerous Moles
❑ Psoriasis
❑ Squamous Cell Skin Cancer
❑ Other (List)

_____

❑ Family History of Melanoma

## MEDICATIONS

Please list all current medications. Please include all prescription, over the counter, herbal and vitamin supplements.

Med Name? Strength? Times per day?

_____

_____

_____

❑ Updated medication list provided

❑ None

## ALLERGIES

Please list all allergies including medications, foods, and environmental.

Allergen Name? Reaction?

_____

_____

❑ No Known Drug Allergies

## SMOKING HISTORY

❑ Never smoked

❑ Current tobacco use

-Interested in more education about smoking cessation ❑ Yes ❑ No

❑ Former smoker

## REVIEW OF SYMPTOMS

Please check all that apply. All unchecked boxes will be interpreted as "no" or "does not apply."

❑ Recent illnesses
❑ Fevers
❑ Weight Loss
❑ Headaches
❑ Problems Seeing
❑ Problems Hearing
❑ Chest Pain
❑ Shortness of Breath
❑ Abdominal Pain
❑ Nausea or Vomiting
❑ Diarrhea
❑ Bloody/Black Stools
❑ Joint Pains
❑ Muscle Weakness
❑ Depression
❑ Thoughts of hurting self or others (this may be reportable.)
❑ Thyroid issues
❑ Liver issues
❑ Kidney Issues

## ALERTS

Please check all that apply. All unchecked boxes will be interpreted as "no" or "does not apply."

❑ Allergy to Lidocaine
❑ Allergy to Marcaine
❑ Reaction to Epinephrine
❑ Allergy to Adhesive
❑ Allergy to Latex
❑ Artificial Heart Valve
❑ Artificial Joint -Was the joint replaced within the last 2 years? ❑ Yes ❑ No
❑ Pacemaker
❑ Defibrillator
❑ Blood Thinners
❑ Premedication Prior to Procedures
❑ Immunosuppression
❑ Pregnant
❑ Breastfeeding
❑ Postmenopausal



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