

PLEASE PRINT 1. _____
LAST NAME FIRST NAME MI BIRTHDATE

2. MARITAL STATUS: SINGLE _____ MARRIED _____ DIVORCED _____ WIDOW(ER) _____ MALE _____ FEMALE _____

3. SOCIAL SECURITY NUMBER: _____ - _____ - _____ HOME # _____

4. ADDRESS: _____

ZIP CODE: _____ WORK# _____ CELL # _____

SPOUSE NAME: _____ PARENT NAME(IF UNDER 18) _____

5. PATIENTS OCCUPATION: _____ EMERGENCY # _____

6. EMPLOYER'S NAME & ADDR: _____

7. RETIRED: YES _____ NO _____ PREVIOUS EMPLOYER IF RETIRED _____

8. NAME OF REFERRING DOCTOR: _____

9. NAME OF FAMILY DOCTOR: _____

ADDRESS: _____

10. NAMES OF OTHER FAMILY MEMBERS SEEN IN OUR OFFICE _____

11. REASON FOR TODAY'S VISIT? _____

12. DO YOU HAVE ANY PERSONAL HISTORY OF SKIN CANCER? YES _____ NO _____ LIST TYPES AND DATES: _____

13. DO YOU HAVE ANY FAMILY HISTORY OF SKIN CANCER? YES _____ NO _____ STATE RELATIONSHIP AND TYPES: _____

14. LIST CURRENT MEDICAL PROBLEMS: _____

15. LIST PAST MEDICAL PROBLEMS AND SURGERIES: _____

16. LIST CURRENT MEDICATIONS	:NAME OF MEDICATION	DOSAGE	FREQUENCY
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

17. YES _____/NO _____: ALLERY TO MEDICATION (S): IF YES, LIST NAME (S) OF MEDICATION(S) AND TYPE OF ALLERGIC REACTION: _____

18. YES _____/NO _____: HAVE YOU EVER HAD ANY PROBLEMS WITH LOCAL ANESTHESIA, BLEEDING, FAINTING, OR KELOID SCARS (ABNORMAL THICKENING)?

EXPLAIN _____

19. YES _____/NO _____: DO YOU HAVE A HEART PACEMAKER OR DEFIBRILLATOR: IF YES, WHERE DO YOU HAVE IT CHECKED? _____

20. YES _____/NO _____: HAVE YOU BEEN TOLD TO TAKE ANTIBIOTICS PRIOR TO SURGERY?

**PLEASE
PRINT**

LAST NAME

FIRST NAME

MI

21. YES ____/NO ____: ARE YOU PRESENTLY PREGNANT OR BREAST FEEDING? IF YOU BECOME PREGNANT, OR YOU ARE BREAST FEEDING WHILE UNDER TREATMENT, PLEASE NOTIFY OUR OFFICE.
22. YES ____/NO ____: DO YOU HAVE A "DO NOT RESUSCITATE" (DNR) ORDER AND/OR A LIVING WILL FORM? THIS FACILITY DOES NOT HONOR A DNR ORDER OR A LIVING WILL.
23. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS BE MADE DIRECTLY TO WESTMORELAND DERMATOLOGY ASSOCIATES FOR SERVICES DESCRIBED:

SIGNATURE:X _____ DATE: _____

I FURTHER AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIM:

SIGNATURE:X _____ DATE: _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS TO ANOTHER PHYSICIAN PARTICIPATING IN MY CARE:

SIGNATURE:X _____ DATE: _____

WHEN PATIENT IS A MINOR OR INCOMPETENT TO CONSENT:

SIGNATURE:X _____ DATE: _____

(MINOR'S PARENT OR LEGAL GUARDIAN ONLY)

* IF YOU ARE GIVING AUTHORIZATION AND/OR CONSENT FOR A PROCEDURE(S) FOR AN ADULT ENTRUSTED IN YOUR CARE, YOU MUST HAVE PROOF OF POWER OF ATTORNEY.

FOR OFFICE USE ONLY

- | | |
|----------------------------------|----------------------------------|
| 1. INSURANCE: _____ | 2. INSURANCE _____ |
| ADDRESS: _____ | ADDRESS: _____ |
| POLICY: _____ | POLICY: _____ |
| GROUP: _____ | GROUP: _____ |
| OTHER: _____ | OTHER: _____ |
| GUARANTOR'S NAME: _____ | GUARANTOR'S NAME: _____ |
| GUARANTOR'S DATE OF BIRTH: _____ | GUARANTOR'S DATE OF BIRTH: _____ |
| RELATIONSHIP: _____ | RELATIONSHIP _____ |
3. INSURANCE: _____

FOR DOCTORS OR PHYSICIAN ASSISTANT'S USE ONLY

WESTMORELAND DERMATOLOGY ASSOCIATES

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Westmoreland Dermatology Associates (WDA) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to WDA's **Notice of Privacy Practices** for a more complete description of such uses and disclosures. Please inform the receptionist if you would like a copy of the Privacy practices.

With my consent, Westmoreland Dermatology may call my home or other designated location and leave a message on voice mail, or in reference to any items that assist the practice in carrying out personal health information, to family members or guardian involved in my care. I have the right to request that WDA restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions; but if it does, it is bound by this agreement.

By signing this form, I am consenting to WDA's use and disclosure of y PHI to carry out TPO. **This consent also authorized the release of any medical information from Westmoreland Dermatology Associates to another physician participating in my care.**

PATIENT ACKNOWLEDGEMENT OF DISCLOSURE INFORMATION

- I am aware of the **Patient Bill of Rights**, as required by law, and have had an opportunity to receive assistance in understanding and exercising these rights.
- I have received (or made available to me) information regarding the health care providers of this organization.
- I am aware of this office's **Notice of privacy practices**, including the **Private Health Information (PHI)** which is available upon request.
- I am aware of the "**Red Flag Regulations**" to prevent identity theft, and the need to provide the organization with a form of photo ID.
- I am aware of the **Infection Control** measures utilized by this organization.
- I am aware of this organization's **Practice Disclosure** and I understand its contents.
- I understand that this practice does not honor **Do Not Resuscitate (DNR) and Living Wills**.

Signature of Patient/Representative

Date