DERMATOLOGY CENTER OF WASHINGTON TOWNSHIP, PC

100 Kings Way East, Suite A-3 • Washington Pavilions • Sewell, NJ 08080 • Phone (856) 589-3331 • Fax (856) 589-3416

Date: _____

PATIENT INFORMATION

Name: _____
(First) (M.I.) (Last) (Suffix)
Street: _____
Zip: _____City: _____ State: _____
Cell Phone: (_____) _____Home Phone: (_____) _____
Email Address: _____ SSN_____
Date of Birth: _____/_____/_____ Age: _____ Birth Sex: _____ Gender Identity:_____
Race: _____Ethnicity (check one): □ Hispanic/Latino □ Not Hispanic/Latino □ Decline to Answer
Marital Status: _____ Employed_____ Retired_____ F/T Student_____ P/T Student____ None_____
Employer: _____ Occupation: _____
Emergency Contact: _____**Phone# :**(_____)_____Relation:_____
Responsible Party: (if patient is minor) Name: _____Relationship:_____
Do you have an Advanced Directive (living will) Yes or No?
If yes name of person _____Phone # of Person_____

PHYSICIAN, LAB & PHARMACY INFORMATION

Physician Requesting Consult: _____ Phone: (_____) _____
City: _____State:_____ Fax: (_____) _____
Primary Care Physician (PCP): (if different) _____Phone: (_____)_____
City: _____State:_____ Fax: (_____) _____
Lab used for blood work: Quest_____ Labcorp_____ Other_____

Pharmacy Name: _____Location/Address: _____
City: _____Phone: ( )_____

INSURANCE INFORMATION

PLEASE NOTE: PLEASE BE AWARE THAT IT IS YOUR RESPONSIBILITY TO HAVE A VALID REFERRAL FOR EACH VISIT.

Primary Insurance Name: _____ Id#:_____
Group#: _____ Insured Name: (if other than self) _____
Insured's Date of Birth: _____/_____/_____Insured's SS#: _____ _____ _____Ph:(_____)_____
Insured's Address (if other than self): _____Zip:_____
City: _____State:_____ Employer: _____
Relationship of patient to insured: Self_____Spouse_____Son_____Daughter_____Stepchild_____Other_____

Secondary Insurance Name: _____Id#:_____
Group#: _____ Insured Name: (if other than self) _____
Insured's Date of Birth: ____/____/_____ Insured's SS#: _____ _____ _____Ph:(_____)_____
Insured's Address (if other than self): _____Zip:_____
City: _____State:_____ Employer: _____
Relationship of patient to insured: Self_____Spouse_____Son_____Daughter_____Stepchild_____Other_____

Prescription Insurance Information (if separate from medical plan):
Name: _____ ID#_____
Group #_____ Phone #_____

DERMATOLOGY CENTER OF WASHINGTON TOWNSHIP, PC
FOR ALL PATIENTS
AGREEMENTS & AUTHORIZATIONS

Changes to health care benefits and coverage can occur at **ANY** time. Therefore, it has become **MANDATORY** and **NECESSARY** to copy **ALL INSURANCE CARDS EACH AND EVERY VISIT.** We are sorry for any inconvenience this may cause.

All Patients:

I request that payment of authorized Medicare and/or insurer benefits be made to me or on my behalf to The Dermatology Center of Washington Township, PC for services furnished to me by said provider. I authorize The Dermatology Center of Washington Township, PC to release to my insurance company any medical information needed to determine the benefits or benefits payable to related services. I understand that if, under my insurance guidelines, a necessary service is determined to be non-covered, and I will personally be responsible for payment. I understand I am financially responsible for any amount denied or partially paid by the Third Party Insurance Carrier. I authorize release of medical information for treatment, payment and healthcare operations. **I understand that I am financially responsible for ANY charges that are not covered by my insurance company.**

Patient Signature: Date:

I understand that insurance co-pays, deductibles, and co-insurances may be collected at time of service.

I understand that office procedures may be applied to my deductible (if applicable), and are due at time of service. Procedures include treatment of skin lesions (including warts, molluscum, moles, precancers, skin cancers) by ANY method (including freezing, biopsy and in-office application of medication). I will be charged the same "allowable" fee that my insurance plan is charged.

I understand that if my insurance plan requires that I obtain a referral from my primary physician, I am responsible to make sure that I have a **VALID** referral for **EACH** and **EVERY** visit, or I will be responsible for **payment in full** for services rendered.

Confirmations: By supplying my home/cell number, email address, or any other contact information, I authorize the practice to contact me at any of the numbers/email address listed using an automatic telephone dialing system, a pre-recorded voice, or other third party automated outreach and messaging system. I consent to the practice, my provider, or their business associates contacting me via unencrypted email and text messages. I also agree that they may leave detailed messages on my voice mail, answering system, or with another person, if I am unavailable at the number provided by me.

MEDICAL RECORDS RELEASE:

I authorize you to release to my insurance company, referring, primary or consulting physicians and pharmacies any information concerning health care, advice, treatment or medication/supplies provided or prescribed to me. This authorization may also include any pictures taken in the office and included in my medical record. This information can be sent by mail, fax or secure internet or given over the phone. Refer to HIPAA Privacy Notice.

HIPAA POLICY: (HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT of 1996) (Updated 2013)

I have been given the opportunity to read and receive a copy of the Dermatology Center of Washington Township, PC's **Notice of Privacy Practices.** The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information. I understand that the Dermatology Center has reserved the right to change their privacy practices that are described in the Notice and that a copy of any Revised Notice will be made available to me.

I acknowledge that I have read the Agreement & Authorization form and agree to its contents.

Patient or Responsible Party

Print: **Signature:** **Date**

Medical History

Patient Name_____ **DOB**_____

Current Medications (prescriptions, over-the-counter meds, vitamins, and herbal supplements):Need Dose, Route Taken, Milligrams, What it is for:_____

_____

Are you allergic to any Medications: YES or NO. If yes list here_____

Do you have now, or have you ever had any of the following diseases, conditions or problems with **(Please check appropriate box)**

Health Questions:	**YES**	**NO**		**YES**	**NO**
Chronic Obstructive Lung Disease	□	□	Diabetes Mellitus	□	□
Cough	□	□	Hyperthyroidism	□	□
Asthma	□	□	Hypothyroidism	□	□
Shortness of Breath	□	□	Epilepsy	□	□
Wheezing	□	□	Total Replacement of right hip joint	□	□
Depressive Disorder	□	□	Total Replacement of left hip joint	□	□
End Stage Renal Disease	□	□	Total Replacement of right knee	□	□
Leukemia	□	□	Total Replacement of left knee	□	□
Malignant Lymphoma	□	□	Arthritis	□	□
Malignant tumor of colon	□	□	Artificial joint in the last 2 years	□	□
History of Colectomy	□	□	Entire transplanted kidney	□	□
Tubal Sterilization	□	□	Heart Transplant	□	□
			Liver Transplant	□	□
Do you have problem with bleeding	□	□	**Dermatology:**		
Blood Thinners	□	□	History of Acne	□	□
Hypertension	□	□	History of Melanoma	□	□
Elevated Blood Pressure	□	□	History of Squamous Cell Carcinoma	□	□
Defibrillator	□	□	History of Actinic Keratosis (pre-cancers)	□	□
Artificial Heart Valve	□	□	History of Basal Cell Carcinoma	□	□
Mechanical Heart Valve	□	□	Allergic to adhesive	□	□
Pacemaker	□	□	Allergic to Lidocaine	□	□
Mitral Valve Prolapse	□	□	Allergic to Topical Antibiotics	□	□
Chest Pain	□	□	Do you pre-medicate before procedures	□	□
Hypercholesterolemia	□	□	Do you develop keloid or hypertrophic scars	□	□
Do you have Anxiety	□	□	Have you had MRSA	□	□
Are you immunosuppressed	□	□	Do you have problems healing	□	□
Seizures	□	□	Do you has a history of rashes	□	□
Do you faint/pass out easily	□	□			

Family history of Melanoma? □ □ **If YES, Who:** _____**Type:** _____ □ **Not Sure**

SOCIAL HISTORY:

Do you smoke, vape or chew tobacco products? **YES or NO** □ Current □ Former □ Never
If YES, how much: _____per day_____ week

Do you drink alcohol? **YES or NO** □ Socially □ Daily □ Never
If YES, how much: _____per day_____ week

IV drug user **YES or NO** □ Current □ Former □ Never If YES, specify:_____

Sexual Orientation_____

What is your occupation?_____

Have you ever been diagnosed with or exposed to **HEPATITIS A, B or C? YES or NO** If YES**, specify which type and when**_____
HIV? □ **YES** □ **NO**
AIDS? □ **YES** □ **NO**

_____

FEMALE PATIENTS ONLY: Currently Pregnant? □YES □NO Trying to Conceive? □YES □NO
Breastfeeding? □YES □NO Planning to get pregnant this year □YES □NO
Using Birth Control? □YES □NO if yes what kind?_____ Date started:_____

Dermatology Center of Washington Township, PC
100 Kings Way East, Suite A-3 Washington Pavilions Sewell, NJ 08080 ▪ Phone: (856) 589-3331

Medical History

Cultural Competency

The state of New Jersey mandates that every physician documents any barrier to care, including cultural and linguistic needs, in the medical record. Factors affecting care are visual or auditory factors, which may impede your ability to comprehend medical discussion and language, cultural and/or religious customs, which may impact the provider's ability to provide medical care. Addressing these needs will improve patient satisfaction and also decrease health care disparities.

PATIENT NAME: _____ DATE OF BIRTH:_____

1. Do you have any impairment? (Please circle any that apply):

    - Visual
    - Hearing
    - Speech
    - Learning
    - Physical
    - Language/Cultural barrier
    - None

2. What language do you speak, read and write?_____

3. Do you have any religious or cultural customs that the doctor should know about? (If choose yes, please explain):

    - Yes, Please explain _____
    - No

4. **ADVANCE DIRECTIVES: FOR ALL PATIENTS 18 YEARS AND OLDER**: Advanced Directive is a federal and state mandated Self-Determination Act enacted in 1990. This allows you to provide specific instruction and direction regarding your own medical care wishes if you become incapacitated. The patient-physician relationship provides a direct opportunity for you to discuss these types of decisions.

    Do you have a "Living Will" or Advance Directive? (Please Circle)

    - Yes Who_____
    - No