Print name:

WILMINGTON DERMATOLOGY CENTER PATIENT HISTORY FORM

Instructions: Please fill out each bubble completely

MEDICAL HISTORY

History of melanoma	☐ Yes	☐ No
History of squamous cell carcinoma (SCC)	☐ Yes	☐ No
History of basal cell carcinoma (BCC)	☐ Yes	☐ No
Change in size, shape, color or sensation in any moles or growths	☐ Yes	☐ No
Hypertension (HTN) [High Blood Pressure]	☐ Yes	☐ No
Hypercholesterolemia [High Cholesterol]	☐ Yes	☐ No
Liver disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Neurological disorders	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Asthma/allergies	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No
Cardiac Valve Disease/Mitral Valve Prolapse	☐ Yes	☐ No
Joint Replacement	☐ Yes	☐ No
Joint pain/arthritis	☐ Yes	☐ No
Autoimmune disease	☐ Yes	☐ No
Currently Pregnant	☐ Yes	☐ No
Currently Breast feeding	☐ Yes	☐ No
Current Irregular periods	☐ Yes	☐ No

FAMILY HISTORY

Melanoma	☐ Yes	☐ No

SOCIAL HISTORY

Are you a? ☐ Current Smoker ☐ Former Smoker ☐ Non-Smoker

How often did you have a drink containing alcohol in the past year?

☐ never ☐ monthly or less ☐ 2 to 4 times a month ☐ 2 to 3 times a week

☐ 4 or more times a week ☐ 6 or more times a week

WILMINGTON
DERMATOLOGY
CENTER

THIS SECTION MUST BE COMPLETED BY ALL NEW PATIENTS: Today's Date _____/ _____/_____

Name: _____

Last First Middle Initial

Permanent Mailing Address: _____

City State Zip

***Primary** Phone: ( )_____ Other: ( ) _____

(* Number to be used for patient reminders & medical results)

Patient's Occupation: _____ Work Phone: ( ) _____Ext:_____

Date of Birth: _____/_____/_____ Age: _____ Sex: ☐ Male ☐ Female

Email address (for appointment reminders)_____

The following are **optional**: Race: _____ Ethnicity: _____ Preferred Language: _____

May we contact you at: ☐ Primary ☐ Other ☐ Work # (check all that apply)

May we leave a message on your answering machine regarding lab / visit / biopsy results? ☐ Yes ☐ No

May we leave a message with any other person? ☐ Yes ☐ No Name: _____

Emergency Contact: _____ Relationship: _____ Contact Number: _____

Preferred Pharmacy: _____ Street Name: _____ Phone #: _____

RESPONSIBLE PARTY (*if different from patient)*

Name: _____

Last First Middle Initial

Address: _____

City State Zip

Primary Phone: ( )_____ Other: ( )_____

Date of Birth: _____/_____/_____ Sex : ☐ Male ☐ Female

Referred By: _____ Primary Care Physician (if different): _____

How did you hear about us (friend, TV, ad, internet, yellow pages, etc. – please describe)? _____

I authorize release of medical information to my Primary Care Dr. / Referring Physician / other consultants if needed.
Signature: _____ Date: _____

Dr. George recommends that all patients 20 & older have a comprehensive skin exam to screen for skin cancer.
Please choose one:

☐ I request a total body exam (included in standard skin check visit)

☐ I decline a total body exam

Turn Page Over to Complete

You are NOT required to complete all the information on this page if you provide your insurance cards to be scanned

INSURANCE COVERAGE – PRIMARY
*(Note: If you provided your primary insurance card to the receptionist, you only need to fill out the **italicized areas** within this section)*

Insurance Co. Name: _____ Phone: ( ) _____ Ext: _____

Address of Claim Center: _____
City State Zip

Name Policy Holder (Insured): _____ ***Insured's DOB:*** _____/_____/_____

Policy #: _____ Group #: _____

Policy Type: ☐ *HMO* ☐ *PPO* *Employer Name:* _____

Employer Address _____

If Patient is a child, check relationship: *Mother* _____ *Father* _____ *Other* _____

INSURANCE COVERAGE – SECONDARY
*(Note: If you provided your secondary insurance card to the receptionist, you only need to fill out the **italicized areas** within this section)*

Insurance Co. Name: _____ Phone: ( ) _____ Ext: _____

Address of Claim Center: _____
City State Zip

Name Policy Holder (Insured): _____ ***Insured's DOB:*** _____/_____/_____

Policy #: _____ Group #: _____

Policy Type: ☐ *HMO* ☐ *PPO* *Employer Name:* _____

Employer Address _____

If Patient is a child, check relationship: *Mother* _____ *Father* _____ *Other* _____

Wilmington Dermatology Center Conditions of Registration and Financial Policy

Patient Name: _____Date of Birth: _____

The following are our conditions of registration as well as our policies with respect to the billing and collections of your account. By signing below, you are agreeing to be bound by these terms.

BASIC POLICY: Payment is due in full at the time service is provided in our office.

FOR PATIENTS WITH MEDICARE: We will bill Medicare on your behalf. As a courtesy, we will also bill secondary insurance carriers on your behalf. You are responsible for all co-insurance payments.

FOR PATIENTS WITH INSURANCE: All co-payments and deductibles are due at the time of service. We will bill insurance carriers on your behalf if we have a current contract with the carrier. Please be advised that your agreement with your insurance carrier is a private one and that ultimately, you are responsible for payment. If an insurance carrier has not paid a claim within 60 days of billing, our fees are due and payable from you. Our office will always strive to help you obtain the maximum possible coverage. It is, however, the patient's ultimate responsibility to determine the extent of coverage allowed by the insurance company.

In addition, preauthorization of a procedure is not a guarantee for payment. Any procedure may be considered not covered under the terms of your agreement with your insurance company. Your insurance carrier will make a determination of payment once the claim is received and reviewed. If after the claim is reviewed and it is determined by your insurance company that the procedure is not covered (cosmetic or not medically necessary), you will be financially responsible to Wilmington Dermatology Center, PLLC for the charges and will be billed for those services not covered by your insurance company.

PATIENTS WHO HAVE A BIOPSY PERFORMED IN OUR OFFICE (INSURANCE & SELF PAY): A biopsy procedure may be performed in our office to assist in diagnosing your skin condition. Biopsies are submitted by Wilmington Dermatology Center (WDC) to a 3rd party board certified dermatopathology provider independent from WDC. The dermatopathology company evaluates the biopsy via microscope and returns a diagnostic interpretation. The act of evaluating your biopsy, performing any testing, and returning a report of their findings is directly billed by the pathology company to you or your insurance, not by WDC. We follow the approach approved by the American Academy of Dermatology for pathology billing, which eliminates any conflicts of interest and avoids any markups that would benefit the dermatologist if they billed for these external services.

NONCOVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or immediately upon notice of insurance claim denial.

MISSED APPOINTMENTS: In fairness to other patients and the doctor, we require at least 24 hours notice to cancel an appointment. You may be charged $50.00 for each appointment that was missed or not canceled with 24 hour notice. Missing more than two appointments without providing 24 hours notice is grounds for discharge from the practice.

RETURNED CHECKS: There will be a fee of $25.00 charged by this office for each check returned to us by your bank.

COLLECTION AGENCY COSTS: In the event your account is referred to a collection agency or attorney for collection, you agree to pay all collection fees, attorney fees, court costs, and expenses.

Turn Page Over to Complete

MEDICARE PATIENTS ONLY: SIGNATURE ON FILE. I request and authorize payments of Medicare benefits be made to Wilmington Dermatology Center, PLLC for any services furnished me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Service and its agents any information needed to adjudicate these benefits for services. I understand my signature requests that payment be made and authorizes release of all information necessary to adjudicate the claim. If "other health insurance" is indicated, my signature authorizes the release of all information to the insurer or agency that is necessary to adjudicate the claim. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and that I am responsible for the deductible, co-insurance, and any non-covered services.

Signature:_____ Date:

All Patients - ASSIGNMENT OF INSURANCE BENEFITS. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Wilmington Dermatology Center, PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not the charges are paid by said insurance. I hereby authorized said assignee to release all information necessary to adjudicate all claims and secure payment for services rendered.

Signature: _____ Date:

If you have a supplemental policy and it is a **MEDIGAP** policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalffor 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.
Signature as it appears on MEDIGAP Card _____ Date _____/ _____/_____

***All Patients* - I have read, understood, and agree to be bound by the terms of this financial policy.**

Signature: _____ Date:

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES OF WILMINGTON DERMATOLOGY CENTER, PLLC

Patient: _____ **DOB: _____**

I hereby acknowledge that I had the opportunity to review the Notice of Privacy Practices of Wilmington Dermatology Center, PLLC. I understand that the Notice of Privacy Practices sets forth my rights relating to the use and disclosure of my personal health information and explains how Wilmington Dermatology Center, PLLC can use and/or disclose my personal health information both with and without my authorization. I understand that I am entitled to receive a copy of the Notice of Privacy Practices* if I so desire. I further understand that I may contact Dr. George if I have any questions regarding the contents of this Notice of Privacy Practices or to file a complaint about the privacy practices of Wilmington Dermatology Center, PLLC.

Signature of Patient or Patient's Representative

Date

_____ _____

*A copy of our Notice of Privacy Practices can be found on our web site, www.wilmingtondermatolgycenter.com. Go to the Patient Information page and click on the Notice of Privacy Practices link. A written copy is also available for review in the office.

Turn Page Over

WDC Skin Care Questionnaire

1. Do you follow a structured skin care regimen today? ☐ or ☐
   a. If Yes – Describe your regimen: _____
2. Would you best describe your skin as oily, dry, or a combination? _____
3. How would you describe your skin's sensitivity? ☐ LOW ☐ MODERATE ☐ HIGH
4. What are your primary skin-related concerns / goals?
   a. _____
   b. _____
   c. _____

Facial Goals: Select your area(s) of concern and identify the location in the space provided.

☐ Correct Facial Sagging, Eyebrow Drop, improve jaw line definition _____
☐ Improve volume in areas (cheeks, lips, etc) _____
☐ Correct facial wrinkles/creases _____
☐ Improve acne / rosacea _____
☐ Get rid of facial veins and/or redness _____
☐ Correct scarring _____
☐ Correct sunspots _____
☐ Correct precancerous spots _____
☐ Improve general appearance of skin tone / health _____
☐ Lengthen and thicken eyelashes _____
☐ Minimize the appearance of under eye bags _____

Body Related Goals: Select your area(s) of concern and identify the location in the space provided.

☐ Remove unwanted areas of fat _____
☐ Remove tattoos _____
☐ Tighten loose skin on arms, and above knees _____
☐ Improve texture of skin (ex. Bumps on backs of arms) _____
☐ Manage chronic skin conditions (ex. psoriasis, eczema) _____
☐ Remove unwanted areas of hair _____
☐ Underarm sweating _____

Do you have an interest in participating in clinical research studies? ☐ or ☐

a. If Yes – Describe your area of interest (ex. Psoriasis, acne,etc) _____

Learn more about our products and services in our waiting room – scan the QR code with your smart phone to visit our website.