

Medicare Patient Information

Patient Name: _____ SS#: _____-_____-_____

Date of Birth: ____/____/____ Sex: Female Male

Address: Street: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____)____-____ Work/Mobile Phone: (____)____-_____

Please print your name as it Appears on Your Medicare Card

Medicare Health Insurance Claim Number as it appears on your card. (This is usually your social security number. Be sure to include the letter after the nine digit number. It is important that we have both the number and the letter.)

Referring Physician: _____ Phone: ()____-_____

Emergency Contact

Name of Spouse, Close Relative or Friend _____
(In Case of Emergency)

Phone: ()____-_____

Please Sign So We May Have Your Medicare Authorization on File:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in the place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Date: ____/____/____ Signature: _____

Payment Policy

Medicare: We are participating providers of the Medicare program. We will accept assignments on all claims. Patients are responsible for meeting their annual \$100.00 deductible and paying for the 20% copayment. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.

Note: If you have recently joined (or changed) to a Medicare HMO, please let our staff know so that we can update your records and advise you if we are participating providers.

Please read each of the following and answer as they apply to you. If it does apply to you, please check YES. If it does NOT apply to you, please check NO.

YES NO

- Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?
- Are you covered by an HMO/PPO which makes Medicare secondary?
- Are you coming to this office for an illness or accident that has been covered or is authorized for coverage from the VA (Veteran's Administration)?
- Do you or your spouse work and have coverage through the insurance at your job?
- Are you eligible for any benefits under the Federal Black Lung program?
- Are you coming to this office for an illness, accident or injury that is the result of an automobile accident?
- Are you coming to this office due to Medicare disability coverage?
- Are you covered by the Federal End Stage Renal Disease Program?
- Are you presently receiving Worker's Compensation?
- Is the illness or injury you are coming to this office for the result of work-related causes?
- Do you have medical assistance through Welfare or state-aid?

If you answered YES to ANY of the above questions: _____

Explain

Policy Number: _____ Group Number _____

Name of Policy Holder (Insured): _____ Male Female

Date of Birth: ____/____/____ Policy Holder (Insured) SS# ____-____-____

Supplemental (MEDIGAP) Insurance

In the event of a major procedure or hospitalization, we may request secondary insurance information for our records (supplemental Medicare insurance information). Please fill out below if you are covered by a plan which covers the 20% NOT covered by Medicare (MEDIGAP Coverage).

Name of Insurance Company: _____

Policy Number _____ Group Number _____

Name of Policy Holder (Insured): _____ Male Female

Date of Birth: ____/____/____ Policy Holder (Insured) SS# ____-____-____

Please Sign So We May Have Your Supplemental Authorization on File:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release the above MEDIGAP carrier for any information needed to determine these benefits or the benefits payable for related services.

Date ____/____/____ Signature _____

Dermatology Medical History

Patient: _____ Date ____/____/____

Reason for today's visit: _____

Are you allergic to any medications? YES NO if yes, list below:

1. _____ 2. _____ 3. _____

Have you ever had any dental anesthesia (novacaine)? YES NO Any bad reaction? YES NO

List ALL the medications you are currently taking (includes prescribed meds, over the counters vitamins, herbals)

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Do you have now, or ever had diseases or conditions of: (Please check YES or NO)

Lungs	YES	NO	Other Systemic:	YES	NO
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst/hunger	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Amputation	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
			Frequency/burning	<input type="checkbox"/>	<input type="checkbox"/>
			Gastrointestinal		
			Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular	YES	NO	Nausea, vomiting, diarrhea,		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infections when taking		
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Limited motion	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of vein	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joint	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

	YES	NO		YES	NO
Skin: Have you ever had skin cancer?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have problems with healing?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family had skin cancer?	<input type="checkbox"/>	<input type="checkbox"/>	Do you develop keloids (<i>scars</i>) after surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of any specific skin diseases?	<input type="checkbox"/>	<input type="checkbox"/>	Do you bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>
Do you develop skin rashes in reaction to: <input type="checkbox"/> Medications <input type="checkbox"/> Food <input type="checkbox"/> Environment <input type="checkbox"/> Bandages <input type="checkbox"/> Topical Neosporin					
<input type="checkbox"/> Other: _____					

Social History:

Do you drink alcohol? YES NO If YES _____ drinks per day
 Do you use IV drugs? YES NO If YES, what? _____ How often? _____
 Do you Smoke? YES NO If YES, how much: _____
 Have you had or have you been exposed to HIV (AIDS)? YES NO
 (Women) Are you pregnant? YES NO Due Date: ____/____/____
 What is your occupation? _____ Hobbies? _____
 Completed by Patient

Medical Assistant _____
 _____ Initials Patient signature _____ Date ____/____/____
 _____ Reviewed by _____ Date ____/____/____

**REFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND
SIGNATURE ON FILE**

Patient Name: _____ Today's Date: ____/____/____

Other family members that are patients: _____

Referred by: _____

Primary Care Physician: _____ Phone: () _____ - _____

EMERGENCY CONTACT INFORMATION:

In case of emergency, who should be notified? _____

Relationship: _____ Phone: () _____ - _____

Do you give our office permission to discuss your medical information with family members?

YES NO If yes, please provide their names and phone numbers below.

Name: _____ Relationship: _____

Phone: () _____

May we leave personal information on your answering machine at home? Yes NO

May we e-mail occasional promotional offers on products and services to you? Yes NO

If yes, please provide your e-mail address: _____@_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature: _____ Date: ____/____/____

PAYMENT POLICY:

HMO, PPO, or other managed care patients: You will be responsible for paying your annual deductible, copayment and charges for any non-covered cosmetic services.

Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 35% of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patient or Responsible Party Signature: _____ Date: ____/____/____

WILDWOOD DERMATOLOGY, P.C.

16516 Manchester Road

Wildwood, MO 63040

Anne T. Riordan, MD

PATIENT STATEMENT OF RESPONSIBILITY

I understand that certain health insurance plans require authorization given by my primary care physician for evaluation / treatment by a specialist. I also understand that certain procedures performed may not be covered by my insurance plan. I understand that there is a possibility that the evaluation / treatment rendered today may not be covered by my health plan. If they are not covered by my health plan, I agree to pay for those services which are not covered.

Signature: _____

Date: ____/____/____