

# Welcome to Water's Edge Dermatology

Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
First Middle Last Insured patients - Name as it appears on your insurance card

Local Address \_\_\_\_\_  
Street Apt. # City State Zip Code

Alternate Address \_\_\_\_\_  
Street Apt. # City State Zip Code

Home Telephone \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  Female  Male

Cell or Alternate \_\_\_\_\_ Social Security Number \_\_\_\_\_

Business Telephone \_\_\_\_\_ Where Employed \_\_\_\_\_

E-Mail Address \_\_\_\_\_  Married  Single  Widowed  Divorced

Spouse/Guardian's Name \_\_\_\_\_ Spouse/Guardian's Employment \_\_\_\_\_

Party Responsible for Payment \_\_\_\_\_ Address \_\_\_\_\_

Insured Name \_\_\_\_\_ Insured Date of Birth \_\_\_\_\_

Insured Social Security # \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Primary Insurance Carrier: \_\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_

Name of Pharmacy You Use \_\_\_\_\_ Phone: \_\_\_\_\_

Who Referred You To This Office? \_\_\_\_\_ Family Physician: \_\_\_\_\_

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## IT IS CUSTOMARY TO PAY FOR PROFESSIONAL SERVICES WHEN RENDERED

### INSURANCE RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Water's Edge Dermatology all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

### FINANCIAL STATEMENT

Payment is required for all services at the time they are rendered unless you are covered by an insurance plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check or credit card. In the event of major procedures, your insurance coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. In the event that your account must be turned over to collections, the collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

### MEDIGAP PATIENTS PLEASE COMPLETE THE FOLLOWING:

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

Signature \_\_\_\_\_

### MEDICAL RECORDS RELEASE:

I hereby authorize Water's Edge Dermatology to obtain medical records, x-rays, lab results, scans, pathology slides from any physician, hospital, clinic where I have been treated. I also authorize Water's Edge Dermatology to release medical records, x-rays, lab results, scans to:

\_\_\_\_\_  
(Referring, Family or Primary Physician).

Physician Name

Signature \_\_\_\_\_ Date \_\_\_\_\_

- PLEASE TURN OVER TO OTHER SIDE -

# MEDICAL HISTORY

Reason for Visit: \_\_\_\_\_

List All Medications Which You Currently Take Including Vitamins, Aspirin or Ibuprofen: \_\_\_\_\_

List Allergies To Medicines \_\_\_\_\_

List All Other Known Allergies \_\_\_\_\_

Are You Allergic to Band-Aids, Tape or Adhesives?     YES     NO

List Recent Operations (Last 3 Years) \_\_\_\_\_

Check ALL Medical Conditions Which You Have Or May Have Had:

- |                                      |  |  |                                       |                                    |
|--------------------------------------|--|--|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Other Cancers | <input type="checkbox"/> Bleeding Tendency         | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Lupus     |
| <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Hay Fever     | <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Convulsions  | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Glaucoma    | <input type="checkbox"/> Hepatitis     | <input type="checkbox"/> Duodenal or Stomach Ulcer | <input type="checkbox"/> Eczema       | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Other _____ |  |  |                                       |                                    |

Do You Have Any of The Following?

- |                                |  |                         |  |
|--------------------------------|--|-------------------------|--|
| Fevers / Chills / Night Sweats | <input type="checkbox"/> YES <input type="checkbox"/> NO | Joint Aches             | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Severe Headaches               | <input type="checkbox"/> YES <input type="checkbox"/> NO | Abdominal Pain          | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Depressions or Anxiety         | <input type="checkbox"/> YES <input type="checkbox"/> NO | Fatigue                 | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Recurrent mouth sores          | <input type="checkbox"/> YES <input type="checkbox"/> NO | Weight loss/gain        | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Shortness of Breath / Asthma   | <input type="checkbox"/> YES <input type="checkbox"/> NO | Diarrhea / Constipation | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Ulcers / Digestive Problems    | <input type="checkbox"/> YES <input type="checkbox"/> NO | Swelling of feet / leg  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Other: _____                   |  |                         |  |

Do You Have an Artificial Heart Valve, Joint or Other Prosthesis?     YES     NO

Do You Require Antibiotics Prior to Dental Procedures?     YES     NO

Have Any of Your Family Members Had Skin Cancer?     YES     NO

If YES, Please Indicate \_\_\_\_\_

Is There Any Other Pertinent Information We Should Know About?     YES     NO

If YES, Please Indicate \_\_\_\_\_

Do You Smoke?     YES     NO

Are You Interested in any of the Following?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Laser Treatment for Blood Vessels | <input type="checkbox"/> Hair Removal       | <input type="checkbox"/> Peels                         |
| <input type="checkbox"/> Sclero Therapy for Leg Veins      | <input type="checkbox"/> Skin Care Products | <input type="checkbox"/> Liposuction                   |
| <input type="checkbox"/> Permanent Make-Up                 | <input type="checkbox"/> Botox              | <input type="checkbox"/> Fillers: Restylane & Radiesse |

FEMALE PATIENTS:

Are You On Birth Control Pills?     YES     NO

Are You Now Pregnant or trying to Become Pregnant?     YES     NO