

WINDSOR DERMATOLOGY PATIENT ENROLLMENT FORM

TODAY'S DATE: _____

Patient Name: _____			
Address: _____		City	State Zip
Street			
Email Address: _____			
Telephone Numbers (provide only if it is OK for us to contact you there!)			
Home: _____	Work: _____	Cell: _____	Other: _____
Date of Birth: _____	Social Security #: _____		
<input type="checkbox"/> FEMALE	<input type="checkbox"/> MALE	Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Name of Employer: _____		Address: _____	
Occupation: _____		School (if applicable): _____	
In case of emergency, please notify: _____			Relationship: _____
Emergency contact home phone: _____		Work phone: _____	Cell phone: _____
Emergency contact address: _____			

PRIMARY INSURANCE - Insurance issued to patient OR insurance issued to spouse or parent covering a patient who otherwise has no directly issued insurance.	SECONDARY INSURANCE - Insurance issued to a spouse that covers a patient who already has primary insurance; insurance covering a child already covered under another parent's plan.
INSURANCE CO: _____	INSURANCE CO: _____
POLICY or ID #: _____	POLICY or ID #: _____
GROUP #: _____	GROUP #: _____
<input type="checkbox"/> Insurance issued to the patient	<input type="checkbox"/> Insurance issued to the patient
<input type="checkbox"/> Insurance issued to the parent	<input type="checkbox"/> Insurance issued to the parent
<input type="checkbox"/> Insurance issued to spouse	<input type="checkbox"/> Insurance issued to spouse
If coverage is via a policy issued to a parent or spouse, please provide that person's:	If coverage is via a policy issued to a parent or spouse, please provide that person's:
NAME: _____	NAME: _____
DATE OF BIRTH: _____	DATE OF BIRTH: _____
SOCIAL SEC. #: _____	SOCIAL SEC. #: _____
ADDR & PHONE (if different): _____	ADDR & PHONE (if different): _____

Primary MD: _____	Phone: _____
Primary MD Address: _____	
How were you referred to this office?: _____	

Please be advised

Our office complies with the Health Insurance Portability & Accountability Act to ensure that all of our patients' information is kept properly confidential. **Unless you notify us otherwise**; we may use and disclose your medical records ONLY for the purposes of treatment (as regards coordination of your care with other providers and services), payment (as regards obtaining reimbursement for services, confirming coverage and billing your insurance company) and Health Care Operations. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services. **Unless otherwise notified by you**, we may at times leave a message at your home phone answering machine, with a family member, or mail information to your home address regarding your medical information.

I have received a copy of this office's Notice of Privacy Practices and understand that my personal information will only be used and/or disclosed as above, and that I have the right to request restrictions concerning the use of my personal information.

PATIENT OR GUARANTOR SIGNATURE: _____

WINDSOR DERMATOLOGY, PC

Jerry Bagel, M.D.

David S. Nieves, M.D.

Judit O. Stenn, M.D.

WELCOME TO OUR OFFICE * THIS INFORMATION MAY SAVE YOU UNNECESSARY EXPENSE!

Please take some time to read our policy on medical insurance plans. Your signature below indicates your understanding and acceptance of our medical insurance policy. Please feel free to discuss any questions with our office staff.

- ◆ **Primary** insurance is coverage through **YOUR** employer or your spouse if you are not employed
- ◆ **Secondary** insurance is additional coverage through a **SPOUSE**
- ◆ **Children** with coverage through both parents will be considered to be primary under whichever parent's birthday falls first in the calendar year

If our office participates with either your primary or secondary insurance, we will submit the claim as appropriate and it is your responsibility at the time of service to provide our office with the following:

- All information that applies to the primary insured including date of birth and social security number
- The insurance claim submission address for both insurance companies
- The co-payment as required by your insurance company

For plans requiring referrals you must have a valid referral, which must be presented prior to service to qualify for your insurance benefit. If you do not have a valid referral as required by your insurance plan:

- You may reschedule your appointment
- If you choose to be seen without a valid referral, you must understand that any charges incurred resulting from this visit will be your responsibility. As per your contract with your insurance carrier, you have agreed to bring a referral coordinated by your Primary Care Physician to be treated by a Specialist. We will submit to your insurance carrier and then bill you preferred provider rates as per the insurance Explanation of Benefits

For plans requiring referrals for maximum or optimal benefits (POS or Point of Service Plans)

- We do not require a referral for these plans, however, it is the responsibility of the insured to be aware of their insurance benefits. If you choose to be seen without a referral you will be responsible for all deductibles or charges as per your contract with your insurance company. We will submit charges with a referral when properly provided to us.
- We will submit to your insurance carrier and then bill you, if necessary, as per the Explanation of Benefits we receive from your insurance company

Following claim submission

- ◆ You will be billed for any deductibles or co-payments as determined by your insurance company.
- ◆ Payment is expected upon receipt of statement from our office.
- ◆ Occasionally, insurance companies will request information from you regarding medical claims. You must respond to these inquiries within 14 days, or you may be held responsible for the entire charge of the medical visit.

Please note cosmetic procedures are not covered by insurance plans and you will be responsible for these charges at the time of service. Your physician will notify you if a procedure is cosmetic and the cost of the procedure before service is rendered. If on the same date of service as a cosmetic procedure you also incur charges that will be accepted by your insurance company, these will be submitted to your insurance carrier on a completely separate basis.

I am aware of, have read the above, and accept the insurance policy of this office as indicated by my signature below.

X

Signature of Patient/Responsible Party

Date

SIGNATURE ON FILE

I authorize use of this form on all my insurance submissions, as well as the release of information to all my insurance companies allowing my physician to submit claims and receive payment for benefits covering services rendered for myself or dependents. I permit a copy of this authorization to be used in place of the original and understand that I am financially responsible for all charges as per my agreement with my insurance company and this office

Name (Please Print)

Date

X

Signature

Windsor Dermatology Medical History Questionnaire

Name: _____ Date of birth: _____ Today's date: _____ (Must complete annually)

HAVE YOU EVER HAD ANY OF THESE?:

- Skin cancer *
- Other cancer *
- Abnormal moles *
- Diabetes
- High blood pressure
- Heart attack
- Congestive heart failure
- High cholesterol
- Mechanical heart valve
- Defibrillator or pacemaker
- Joint replacement
- Tuberculosis or (+) PPD
- Hepatitis B or C
- Serious or recurrent infections *
- Multiple sclerosis
- Thyroid problems *
- Kidney/urinary problems *
- Liver problems *
- Stomach or bowel disorders *
- Lupus
- Rheumatoid arthritis
- Depression or bipolar
- Psoriasis
- Eczema
- Asthma or other lung problems
- Anemia or iron deficiency
- Bleeding disorders *
- Eye disorders *
- Organ transplant *
- Surgery *
- Other condition not listed *

DO YOU HAVE ANY...

- New moles or growths
- Changing moles or growths
- Irritated moles or growths
- Blood relatives with melanoma?
- Joint pain
- Fever (w/current skin problem)
- Feel unusually fatigued?
- Unintended weight loss
- Feel excessively warm or cold
- Tingling in fingers or toes
- Difficulty sleeping due to discomfort from skin condition
- (Women) Irregular periods?
- (Women) Are you currently pregnant?
- (Women) Are you attempting pregnancy now or expect to do soon?
- (Women) Are you breastfeeding?

If yes, explain

PLEASE LIST YOUR CURRENT MEDICATIONS

ALLERGIES

- If yes, please list: _____

ARE YOU INTERESTED IN LEARNING MORE ABOUT...

- Removal of unwanted skin tags?
- Erasing unwanted spider veins?
- Wrinkle correction with BOTOX, Juvederm, Restylane, or collagen?

* If you answered yes to any item with an asterisk (*) please explain here:

NEW ACNE PATIENTS: CIRCLE ANY MEDICINES YOU HAVE TRIED ALREADY

Retin-A Differin Tazorac Duac Benzaclin Clindagel clindamycin Klaron Plexion sulfur washes benzoyl peroxide ProActiv doxycycline/Doryx/Adoxa tetracycline minocycline/Dynacin/Minocin/Solodyn Accutane

NEW PSORIASIS PATIENTS: CIRCLE ANY MEDICINES YOU HAVE TRIED ALREADY

Topical steroids: clobetasol, Clobex, Olux, Taclonex, betamethasone, Ultravate, halobetasol, triamcinolone, desonide, hydrocortisone

Other topical: Dovonex, Tazorac, tar, Protopic, Elidel

Phototherapy with UVB or PUVA

Oral therapies: methotrexate, Soriatane, cyclosporine/Neoral, Tegison

Biologic therapies: Enbrel, Humira, Raptiva, Amevive, Remicade

OFFICE USE ONLY

Reviewed (Doctor/PA signature): _____ Date: _____