PATIENT INFORMATION (Please Print) Today's Date ___/___/___

Name _____
Last First M.I.

Mailing Address _____
City State Zip

Home Phone _____ Work Phone _____ SS # _____
Area Code Area Code

Date of Birth ___/___/___ Age _____ Sex _____ Marital Status _____

PATIENT OR RESPONSIBLE PARTY (If different form patient) Email: _____

Name _____
Last First M.I.

Mailing Address _____
City State Zip

Home Phone _____ Work Phone _____ SS # _____
Area Code Area Code

Date of Birth ___/___/___ Sex _____ How did you hear about us? _____

INSURANCE INFORMATION (Please present Insurance card at time of check In.)

Primary Insurance Name X _____
Ins. Address X _____
Name of Insured X _____
Insured's ID# X _____
Group # X _____
Employer Name _____
Employer Address _____
Employer Phone _____
Area Code
Relationship of patient to the Insured X _____

Secondary Insurance Name _____
Ins. Address _____
Name of Insured _____
Insured's ID# _____
Group # _____
Employer Name _____
Employer Address _____
Employer Phone _____
Area Code
Relationship of patient to the Insured _____

Other family members that are patients _____

Pharmacy of choice _____ Phone _____

In case of Emergency, who should be notified? _____ Phone _____

Referred by: _____

Primary Care Physician _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature X _____ Date X ___/___/___

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable copayments and deductibles will be collected.We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be preverified and you will be asked to pay any unmet deductible, non-covered services and copayments. In the event that your account must be turned over to collections, a collection fee of 28% will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature X _____ Date X ___/___/___

☐ Copy of Insurance card (both side) attached. ☐ Updated By: _____

Medical History

Patient:_____ Date: _____

Reason for today's visit: _____

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

1. _____ 2. _____

List all Medications you are currently taking:

1. _____ 3. _____

2. _____ 4. _____

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

Lungs:	YES	NO	**Other Systemic:**	YES	NO
Bronchitis	❑	❑	Diabetes	❑	❑
Emphysema	❑	❑	Thyroid	❑	❑
Asthma	❑	❑	Kidney	❑	❑
Chronic Cough	❑	❑	Bladder	❑	❑
Morning Cough	❑	❑	Stomach	❑	❑
Vascular:			Bowel	❑	❑
			Hepatitis or Yellow Skin	❑	❑
High Blood Pressure	❑	❑	Glaucoma	❑	❑
Chest Pain	❑	❑	Arthritis/Joint Deformity	❑	❑
Heart Attack	❑	❑	Convulsions, Epilepsy or Seizures	❑	❑
Heart Murmur	❑	❑	Fainting	❑	❑
Irregular HeartBeat	❑	❑			
Pacemaker	❑	❑			
Phlebitis	❑	❑			

Do you drink alcohol? ❑ YES ❑ NO If YES _____ drinks per day

Do you use IV drugs? ❑ YES ❑ NO If YES what? _____ How much ? _____

Have you had or have you been exposed to HIV (AIDS) ? ❑YES ❑ NO

Have you ever had dental anesthesia (Novacaine)? ❑YES ❑NO Any bad reaction? ❑YES ❑NO

Skin:

When you are exposed to sun do you: ❑ Tan only ❑ Tan and burn ❑ Burn

Have you ever had skin cancer? ❑ YES ❑ NO

Has anyone in your family had skin cancer? ❑ YES ❑ NO If Yes, Who? _____

Do you have a history of any specific skin diseases? ❑ YES ❑ NO

If yes, please list: _____

List any other disease or condition we should know about: _____

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

Please answer the following questions:

A. Do you smoke? ❑ YES ❑ NO If yes, how much:

B. Do you bleed easily? ❑ YES ❑ NO

C. (Women) Are you pregnant? ❑ YES ❑ NO Due Date: _____

D. Do you have artificial joint(s) ? ❑ YES ❑ NO

E. What is your occupation ? _____

F. What are your hobbies? _____

Completed by: ❑ Patient

❑ Medical Assistant _____
Initials

_____
Signed by Physican Date

_____
Reviewed by Date

DERMATOLOGY CENTRE

PLEASE READ AND SIGN BELOW SO WE CAN UPDATE YOUR FILE

I GIVE PERMISSION TO DR. JAMES R. WATT AND HIS MEDICAL STAFF TO DISCUSS MY CONDITION WITH MY FAMILY MEMBERS OR OTHER PERSONS SPECIFIED, UNLESS NOTIFIED OTHERWISE IN WRITING. PLEASE SPECIFY ANY OTHER ADDITIONAL PERSON(S) THAT YOU MAY WANT ME TO CORRESPOND WITH:

_____

_____

_____

_____

PATIENT'S NAME (Please Print)

X_____

PATIENT'S SIGNATURE

X_____

DATE

DERMATOLOGY CENTRE

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I _____, HAVE RECEIVED A COPY OF THE DERMATOLOGY CENTRE NOTICE OF PRIVACY PRACTICES.

X _____
SIGNATURE OF PATIENT

X _____
DATE