Dermatology Associates
of Western Connecticut, PC

Date of Appointment:

Account #:

PATIENT INFORMATION:

PLEASE PRINT CLEARLY

Prefix (circle one): Mr. Mrs. Miss Ms.

First Name: _____ Middle Initial: _____ Last Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Date of Birth: _____ Gender: _____ Marital Status: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Email: _____

Preferred Contact: *please **fill in and circle** your preferred phone contact method(s)*

Home #: _____ Work #: _____ Mobile #: _____

Can we leave a message on the voicemail of your preferred contact number? YES ❑ NO ❑

Patient's Employer or School (if student): _____

Primary Care Physician: _____ Town/City: _____

Name of person that referred you: _____ Physician ❑ Friend ❑ Relative ❑ Self ❑ Other ❑

In case of EMERGENCY, please call: FULL Name: _____

Emergency Contact's #: _____ Relationship to Patient: _____

HIPAA (must be completed): I give DAWC permission to speak with the following person(s) regarding **my medical conditions, lab results, or financial information:**

Full Name: _____ Relationship to Patient: _____

Full Name: _____ Relationship to Patient: _____

***** If you would like us to discuss your information with ONLY you, please check box ❑ & Initial: _____**

INSURANCE INFORMATION: ***COMPLETE to ensure proper billing – If patient is the POLICYHOLDER, circle SELF; no need to fill out.***

Is patient 'Self Pay'? ❑ Yes ❑ No **Is patient privately insured?** ❑ Yes ❑ No

Primary Insurance Information:

*Insurance Company Name: _____ *Policyholder Name: _____

*Date of Birth: _____ *Relationship to Patient: _____ / **SELF**

*Policyholder's Address: _____

*City, State, Zip: _____ *Policyholder's phone #: _____

*Policyholder's Employer: _____ If unemployed, Check box ❑

Secondary Insurance Information (if applicable):

*Insurance Company Name: _____ *Policyholder Name: _____

*Date of Birth: _____ *Relationship to Patient: _____ / **SELF**

*Policyholder's Address: _____

*City, State, Zip: _____ *Policyholder's phone #: _____

*Policyholder's Employer: _____ If unemployed, Check box ❑

FLIP & SIGN →

Account #: -25

Payment/Financial Policy

We accept: VISA, MASTERCARD, AMEX, DISCOVER, CASH AND CHECKS.

For HMO, PPO, Medicare or other managed care insurance plans: You will be responsible for paying any deductibles, coinsurance, copay and charges for any non-covered cosmetic services.

Payment of copay is required at the time of service. A $10.00 surcharge will be charged to any patient that does not pay the copay at the time services are rendered.

Private Insurance Patients: Patients who are covered by private commercial plans in which our physicians are not providers will be required to pay the total bill at the time of service. An insurance claim form can be mailed to you to use for submission of the bill to your insurance carrier at your request.

Patients with No Insurance or 'Self Pay' Patients: Full payment is required at the time of service.

Pathology Services: If a growth or lesion is removed or a specimen is collected during your visit, you will incur additional costs for laboratory services to process and diagnose your sample, either by our in-house laboratory or an outside laboratory facility. Depending on the complexity of diagnosing the specimen, there may be additional charges. Other terms that may be utilized to describe these procedures include, but are not limited to: biopsy, shave, excise/excision, punch, culture, scraping, or clipping.

For Cosmetic or Any Medically Unnecessary Procedures: Full payment is required at the time of service. A $150 deposit is required for all cosmetic procedures; please note that cosmetic deposits are non-refundable and will be forfeited if not used within 6 (six) months of date of deposit.

Cancellation/NO Show Policy: We require 24-hour notice for cancellations. If you fail to cancel your medical appointment within this time frame, or do not show for your appointment, a fee of $50.00 will be charged to your account. Cancellation/No show of a cosmetic appointment within the 24-hour time frame will result in a $150.00 fee charged to your account. Cancellation/No show of a Mohs appointment within the 24-hour time frame will result in a $150.00 fee charged to your account.

Returned Checks (bounced/insufficient funds): Returned checks will result in a $25.00 insufficient check charge to be added to your account balance.

Authorization, Release & Confidentiality

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

I understand that DAWC may, at times, send me emails promoting health education and/or in-office promotions. I may request in writing that I do not want to receive any such emails from DAWC. My signature also designates that I understand DAWC's prescription refill policy.

Further, my signature indicates that I understand and accept the financial policy described above. All therapeutic communications, records, and contacts with the Dermatology Associates of Western Connecticut staff will be held in strict confidence in accordance with the Health Insurance Portability & Accountability Act (HIPAA). I can request my medical records in writing via mail or fax. If I have any questions, your staff is trained to assist me.

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Our Notice of Privacy Practice (NPP) provides information about how we may use and disclose protected health information (PHI) about you. It discusses your rights as a patient and Dermatology Associates of Western Connecticut's duties with respect to your PHI. You have the right to review our policy before signing this acknowledgement. If we change our Notice you may obtain a revised copy by contacting our office or from our website: www.dermwestconn.com. Your signature acknowledges your receipt of our NPP.

_____ _____

Signature of patient or legal guardian Date

Patient Name:
D.O.B:

Acct#:
Date:

Confidential Medical History

Do you have now, or have you ever had any of the diseases or conditions listed below? (Please check YES or NO)

	YES	NO
Anxiety or Depression	☐	☐
Arthritis/Joint Deformity	☐	☐
Asthma	☐	☐
Bleeding Disorder	☐	☐
Blood Clots	☐	☐
Cancer	☐	☐
Type: _____		
Colon / Bowel Disease	☐	☐
Defibrillator / Pacemaker	☐	☐
Depression	☐	☐
Diabetes	☐	☐
Emphysema (COPD)	☐	☐
Eye Disorder	☐	☐
Heart Disease or Issue	☐	☐
Hepatitis	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐

	YES	NO
HIV/AIDS	☐	☐
Joint Replacement	☐	☐
Kidney Issues	☐	☐
Lyme Disease	☐	☐
Mood Disorder	☐	☐
Multiple Sclerosis	☐	☐
Neurological Disorders	☐	☐
Type: _____		
Osteoporosis	☐	☐
Reflux	☐	☐
Seasonal Allergies	☐	☐
Seizures	☐	☐
Stomach Issues / Ulcers	☐	☐
Stroke	☐	☐
Thyroid Disorder	☐	☐
Tuberculosis		

List any other diseases or conditions we should know about:

1. _____
2. _____
3. _____

Patient Height: _____ ft. _____ in.

Patient Weight: _____ lbs.

Please list **ALL** (prescription and over the counter) medications (internal or topical) you are taking or have taken/used in the last 7 days:

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

Please list any surgical procedures you have had in the last 6 months: _____

Please list allergies to any medications or local anesthetics: _____

Skin History:

	YES	NO	
Have you ever had a skin cancer?	☐	☐	If yes, what type? _____
Has anyone in your family had a skin cancer?	☐	☐	If yes, who? _____
Has anyone in your family had a malignant melanoma?	☐	☐	If yes, who? _____
Have you had any specific skin diseases or skin problems?	☐	☐	If yes, please list: _____
Do you use sunscreen?	☐	☐	If yes, what type and SPF? _____

UV Exposure History (check all that apply):

I avoid the sun	☐
I am frequently in the sun	☐
I've had some sun exposure	☐
I have used a tanning bed in the past	☐
I currently use a tanning bed	☐

Sunburn History (choose one):

I have no history of sunburn	☐
I have had less than 5 sunburns	☐
I have had more than 5 sunburns	☐
I have had 1 or more sunburns that blistered	☐

Other History:

	YES	NO	
Do you drink alcohol?	☐	☐	If yes, how much? _____
Do you use or have a history of using tobacco products?	☐	☐	If current, how much? _____
			Type of tobacco product used: _____
Female patients, are you pregnant ❑ or nursing ❑ ?		☐	If pregnant, due date: _____

Patient Signature: _____