Center for Dermatology, P.A.
128 Columbia Turnpike, Suite 200
Florham Park, NJ 07932
(973) 736-9535
Centerfordermnj.com

Patient Number:

PATIENT INFORMATION

Patient name (Last, First, M.I.) Today's Date:

Patient Address City State Zip Code

Patient Social Security No. Home Phone No. Work Phone No. Cell
- - ( ) ( ) ( )

Marital Status: Age Date of Birth Sex
☐ Divorced ☐ Widowed ☐ Single / / ☐ Female
☐ Married ☐ Civil Union ☐ Male

Were you referred by a doctor? Referring Doctor's Name: Referring Doctor's Phone No.
☐ Yes ☐ No

How did you hear about the Center for Dermatology? _____

Is your visit today related to an accident at work? Yes____ No____ If Yes Explain: _____

EMPLOYMENT INFORMATION

Patient's Employer_____ Occupation_____ Employer_____

Address_____ Work Phone No. _____

INSURANCE SUBSCRIBER'S INFORMATION

Subscriber's Name: _____

☐ Same as above Relationship to patient: _____

Subscriber's Address: _____

☐ Same as above

Subscriber's Social Security No._____ Subscriber's D.O.B._____Phone No._____

IMPORTANT:
AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS, RELEASE OF INFORMATION AND FINANCIAL AGREEMENT

RELEASE OF INFORMATION: I authorize the release of any medical information or billing information to any covered entity, i.e.: health plan or payer, physician, hospital or pharmacy regardless of any diagnosis in accordance with the Heath Insurance Portability and Accountability Act.

ASSIGNMENT OF INSURANCE BENEFTIS: If the patient is covered by insurance, I hereby assign, transfer, and set over the Center for Dermatology, P.A. all of my rights title and interest to medical reimbursement, and all other rights and privileges otherwise payable to me for those services provided the Center for Dermatology, P.A.

✷ Each patient will be individually evaluated to determine if assignment of insurance benefits is accepted.

AGREEMENT TO PAY FOR SERVICES: For and in consideration of services rendered or to be rendered by the Center for Dermatology, P.A. to the patient named above, I hereby guarantee payment of any and all bills rendered for said patient which are not covered or allowed by insurance together with collections costs. I agree to personally assume **any and all** responsibility for **any and all** laboratory tests and/or biopsies not paid for by my medical insurance.

MEDICARE BENEFITS AUTHORIZATION: "I request that payment of authorized Medicare Benefits be made my behalf to the Center for Dermatology, P.A. for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Heath Care Financing Administration and its agents any information needed to determine those benefits payable for related services."

Both signatures required:

RESPONSIBLE PARTY SIGNATURE: _____DATE: ____/____/____

☐ **I ACKNOWLEDGE RECEIPT OF HIPPA PRIVACY REGULATIONS AS THEY PERTAIN TO THE CENTER FOR DERMATOLOGY.**

SIGNATURE: _____ DATE: ____/____/____

NAME:_____ **DATE OF BIRTH:**_____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid reflux)
Hearing Loss
Hepatitis
Hernia Repair
High Blood Pressure
High Cholesterol
HIV/AIDS
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other _____

Past Surgical History: (please circle all that apply)

Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Transplant
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
None
Other _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
Indoor Tanning History
None
Other _____

PLEASE COMPLETE OTHER SIDE -→

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____

Medications and Dosage: (Please enter all current medications and dose)
_____
_____
_____

Allergies: (Please enter all allergies)
_____
_____

Have you received the following immunizations: (Yes/No)

Flu_____ Pneumonia_____

Social History:

Cigarette Smoking:	Alcohol Use:	Gender:	Race:
Never smoked	Yes	Male	Caucasian
Quit: former smoker	No	Female	African American
Smokes less than daily			Asian
Smokes daily			

Home Address: _____

Telephone Number(s): _____

Email address: _____

Occupation and Workplace: _____

Pharmacy Name: _____
Pharmacy Address: _____

Referring Physician Name: _____
Primary Care Physician: _____

Primary Subscriber on Insurance
Name: _____
Date of Birth: _____

Center for Dermatology, PA

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973-736-9535
Fax 973-736-2607

To Our Patients:

In an effort to streamline patient billing and to avoid collection issues, we have initiated a policy where we will maintain an imprint of your Visa, MasterCard or American Express information. This is completely VOLUNTARY.

Patients with out-of-network insurance will be charged at the time of service.
We will collect payment at the visit and provide a statement that you can submit to the insurance company for possible reimbursement.

Patients with no insurance will be charged at the time of the visit.

For patients with participating insurances, payments from the insurance company will be applied before the credit card is charged for any remaining balance.
For balances exceeding $500, we will call before charging the credit card.

We value your business and will protect your privacy at all times. If you have any questions, please do not hesitate to call our Billing Department and to ask for Diane or Doreen.

Thank you for your cooperation.

Patient Name_____

Visa_____ MasterCard_____ American Express_____

Card Number_____ Exp. Date_____

Security Code_____
Note: AMEX has a 4-digit code on the front of the card

Patient Signature_____

Date_____