CENTER CITY DERMATOLOGY – STEPHEN HESS, M.D., Ph.D.
MEDICAL HISTORY

Name_____ Age_____ Date of Birth_____

Reason for today's visit _____

Who referred you to this office?_____

Who is your primary care physician?_____

Are you allergic to any medications? _____Yes _____No If yes, list_____

Have you ever had bad reaction to dental anesthesia (Novocain)? _____

List all medications you are taking including non-prescription and over the counter

_____

_____

Are you taking blood thinners (Aspirin, Plavix, Coumadin, Motrin, Advil, Ginkgo)? _____

Have you ever had diseases or conditions of the following? Please fill in all that apply.

Emphysema O Yes	Asthma O Yes	Seasonal allergies O Yes
HIV O Yes	High Blood Pressure O Yes	Diabetes O Yes
Gout O Yes	Arthritis O Yes	Anemia O Yes
Seizures O Yes	Heart murmur O Yes	Phlebitis O Yes
Artificial Valves O Yes	Pacemaker O Yes	Stroke O Yes
Irregular heartbeat O Yes	Hepatitis C O Yes	Hepatitis B O Yes
Lupus O Yes	Artificial joint O Yes	Heart Attack O Yes
High Cholesterol O Yes	Glaucoma O Yes	

Other organs	**Details**
Thyroid disease O Yes	_____
Kidney disease O Yes	_____
Bladder problems O Yes	_____
Stomach O Yes	_____
Bowel O Yes	_____
Cancer O Yes	_____

List any other diseases or conditions we should know about_____

List any surgical procedures in the last 6 months_____

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Name_____ Date of Birth_____

Without sunscreen you: O tan only O burn then tan O burn only

Have you had skin cancers? O Yes O No If yes, what kind_____

Have you had skin diseases? O Yes O No If yes, please list: _____

Any family member with **melanoma**? O Yes O No If yes, who?_____

Do you drink alcohol? O None O Occasionally O More than 8 drinks/week

Do you or did you ever smoke?_____ Quit Date:_____

Have you ever-used IV or recreational drugs? O Yes O No

What drug?_____

Recent travel outside US in the last 3 months? O Yes O No

Occupation _____

Do you have or have had the following symptoms in the last 2 weeks? **Please fill in all that apply**.

Fever O Yes Weight loss O Yes Shortness of breath O Yes

Fatigue O Yes Vision change O Yes Burning on urination O Yes

Cough O Yes Easy bruising or bleeding O Yes Chest pain O Yes

Muscle pains O Yes Joint pains O Yes Nausea, vomiting, diarrhea O Yes

Runny nose O Yes Depressed moods O Yes

Night sweats O Yes Headache O Yes

Women: are you pregnant? O Yes O No O Not sure O Planning

Women: are you menstrual periods regular? O Regular O Irregular

Women: are you breastfeeding? O Yes O No

CENTER CITY DERMATOLOGY

1500 Walnut Street, Suite 1240
Philadelphia, PA 19102
Phone: 267-687-4437 Fax: 267-687-4438

REGISTRATION FORM

(Please Print)

Today's date:						
PATIENT INFORMATION						
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Social Security no.:	Home phone no.: ( )			
P.O. box:	City:	State:	ZIP Code:			
Occupation:	Employer:	Employer phone no.: ( )				
Race:	**Ethnicity :**	Language:				
Primary Care Physician:	Phone No. ( )					
Referring Physician:	Phone No. ( )					
PHARMACY :	**PHARMACY LOACTION:**					
IN CASE OF EMERGENCY						
Name of local friend or relative :	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )			

AUTHORIZATION:

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. ALL COPAYS ARE PAYABLE AT THE TIME OF SERVICE.

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I HERBY AUTHORIZE CENTER CITY DERMATOLOGY TO FURNISH INSURANCE COMPANIES OR THEIR REPRESENTATIVES INFORMATION CONCERNING MY (MY DEPENDENTS) ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO CENTER CITY DERMATOLOGY ALL PAYMENTS FOR MEDICAL SERVICES RENDERED BY MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

HIPAA ACKNOWLEDGEMENT:

I HAVE RECEIVED AND HAVE READ CENTER CITY DERMATOLOGY NOTICE OF PRIVACY PRACTICES.

IN MY ABSENCE OR FOR THE BENEFIT OF GAINING MEDICAL ADVICE ON MY BEHALF, I AUTHORIZE THE FOLLOWING PERSON TO GAIN PATIENT HEALTH INFORMATION FOR OR WITH ME:

_____

(Please list authorized Representative(s) or mark N/A)

_____ _____

Patient or Parent/Guardian signature ***Date***

CENTER CITY DERMATOLOGY

FINANCIAL POLICY

We would like to take this opportunity to welcome you to our office and assure you that we will do our best to provide you with quality medical care.

PATIENTS WITH INSURANCE COVERAGE

CENTER CITY DERMATOLOGY makes every effort to accept a broad range of major insurance carriers. However, due to the ever changing nature of health care insurance, you should **always check with your specific company to ensure CENTER CITY DERMATOLOGY is in network**.

We will be happy to help you obtain the appropriate benefit from your insurance carrier. We will bill your insurance carrier as a courtesy to you. However, you are responsible for the payment of the account. **Portions of the bill that are required to be paid by the patient, as per your insurance agreement, are your responsibility. These may include co-payment, co-insurance, and deductible. In the event of an outstanding balance, your account will be forwarded to a collection agency if greater than sixty (60) days past due.**

If you are covered by an HMO, you are required to have a referral from your primary care doctor for **all** visits to CENTER CITY DERMATOLOGY. It is your responsibility to ensure that a referral is issued. Because we are Specialists we **CANNOT** see you without a referral from your primary care physician.

PATIENTS WITHOUT INSURANCE COVERAGE

Patients without insurance coverage are requested to pay for services as rendered.

APPOINTMENT CANCELLATION POLICY

If you are unable to keep your appointment, please call our office to cancel or reschedule at least 2 business days (Monday – Friday) in advance. No-shows or appointments cancelled within 2 business days will be charged $ 50.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY AND APPOINTMENT CANCELLATION POLICY OF CENTER CITY DERMATOLOGY.

_____ _____

Signature of Patient or Parent/Guardian Date