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

Name____ Age______ Date of Birth___________

Email ____

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_____________________________________

CENTER CITY DERMATOLOGY - STEPHEN HESS, M.D., Ph.D.
MEDICAL HISTORY -Page 2

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
REGISTRATION FORM – PAGE 3

(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 / Partner

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F ❑Transgender

Street address:	Social Security no.:	Primary phone no. (home / cell): ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )
Race:	**Ethnicity :**	Language:

Policy Holders Name:	Relation to Policy Holder: ❑ Self ❑ Parent ❑ Spouse
Primary Care Physician:	Phone No. ( )
Referring Physician:	Phone No. ( )
PHARMACY :	**PHARMACY LOCATION:**

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 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 Signature (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 deductibles. 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 **at least 24 business hours** (Monday-Friday). We will be able to help you reschedule that appointment at a more convenient time. Failure to show for your appointment or late cancelations will result in a **$50 fee**. Cancellation of a surgery or cosmetic appointment will result in a **$150 fee**. Please understand that we have set aside this time especially for you and your needs.

Aesthetics Cancellation Policy

Due to the demanding schedule of our aesthetician, appointments are precious. If you are unable to keep your appointment please call our office **at least 24 business hours** in advance Monday-Friday. First time appointments must be **paid in advance** in order to schedule. Late cancelation or failure to appear for your appointment will result in you being charged **the full amount** of your treatment. Please understand that we respect your time and will do everything in our power to stay on schedule. This also means that if you are late for your appointment, you may be asked to reschedule, which may also result in a charge. We recommend arriving 10-15 minutes prior to your scheduled appointment time.

*   *   *

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

____

Patient Signature (or Parent/Guardian Signature) Date