PATRICK A WEGMAN MD
DERMATOLOGY

PATIENT CONTACT INFORMATION

Name: ________________________________**Middle Initial**_____ **Age:** ________ **Birth Date:** ___________________

Primary Phone #: (______) ______________________________**Secondary Phone#:**(______) _____________________

May we leave message for you at the above listed phone number(s)? YES NO

Address: ____ **Email address:** ____________________________________

City, State, Zip: ______________________________________ **Gender Identification:** __________________________

Social Security Number: ______________________________ **Marital Status:** S M W D

Primary Doctor(s): _______________________________ **Pharmacy:** _____________________________________

I have an: Durable Medical Power of Attorney___ Advanced Directives __ (Please Provide Copy at Appointment if possible)

Patient's Occupation & City: ____ **Hours of Work:** ______________

Work Phone: _________________________________**You may leave a message for me at work:** Yes No

Significant Other Name: ___________________________**Significant Other Phone #:**___________________________

Significant Other Work Phone: ______________________**You may leave a message for my significant other at work:** Yes No

If Minor, Parent Name:________________________________ **If Minor, Parent Phone #:**____________________

Parent's Employer:___________________________________ **Parent's Work Phone:** _________________________

Legal Guardian:____________________________________ **Guardian's Best Contact Number:**____________________

If patient is under the age of 18 OR has legal guardian, the patient's parent and/or legal guardian must be present at all appointments.

DESIGNATED REPRESENTATIVE(S) INFORMATION

Our office staff may discuss your test results or other medical information regarding your care with the person(s) listed below:
****Please note that we will not leave any medical information on an answering machine****

(Your information may not be discussed with your spouse, parent, or any other person unless listed in this section of the form.)

- Name: ____________________________________ Phone #____________________ Relationship: ______________
- Name: ____________________________________ Phone #____________________ Relationship: ______________
- Name: ____________________________________ Phone #____________________ Relationship: ______________
- ***No – I **do not** want my medical or any other information discussed with my spouse or any other person ______***

EMERGENCY CONTACT INFORMATION

Please provide the name(s) of person(s) **NOT living in your home. This person would ONLY be contacted if we were UNABLE to reach you at your phone number(s) and/or address provided. We will NOT provide medical information to these people.**

Name ____ **Phone** __________________ **Relationship**_________________

Name ____ **Phone** __________________ **Relationship**_________________

PATRICK A WEGMAN MD
DERMATOLOGY

PATIENT NAME: ____

DOB:___________**TODAY'S DATE:** ________________________

SKIN CONDIITONS	No	Yes	Onset/Type
Have you had skin cancer?			
Melanoma?			
Basal Cell Carcinoma?			
Squamous Cell Carcinoma?			
Have you had an abnormal moles?			
Have you had pre-skin cancer lesions?			
List any other skin conditions: (Examples: Eczema, Psoriasis, Acne, Rosacea, etc…) ___________________			
Do you use sunscreen? SPF #____			
Have you used tanning beds in the past?			
Do you currently use tanning beds?			
Have you had blistering sunburns?			
Do you heal with thick (Keloid) scars?			
Do you need antibiotics for the Dentist?			
Do you work outdoors?			
Have you had Staph infections/MRSA?			

PAST SURGICAL HISTORY	NO	YES	YEAR/TYPE
Pacemaker/Defibrillator			
Orthopedic/Joint Replacement-Site:_________			
Heart Bypass/Stents			
Heart Valve Replacement			
Organ Transplant-Type:________			
Cancer			

FAMILY MEDICAL HISTORY	NO	YES	ONSET/TYPE
Skin Cancer?			
Abnormal Moles			
Eczema			
Asthma			
Seasonal Allergies			
Psoriasis			
Autoimmune Diseases (Lupus, Rheumatoid Arthritis, MS, Crohn's Colitis, Thyroid, etc…)			

PERSONAL MEDICAL HISTORY	No	Yes	Onset/Type
Alzheimer's Disease/Dementia			
Arthritis			
Asthma			
Back Problems			
Blood Disorder/Anemia			
Depression/Anxiety			
Diabetes			
Digestive/Bowel Disorder			
Emphysema / COPD			
Glaucoma/ Cataract			
Hay Fever			
Headaches___ Migraines___			
Hearing Loss			
Heart Disease (Heart Attack, Atrial Fibrillation, etc…)			
Hepatitis – A, B, or C?			
High Blood Pressure			
High Cholesterol			
HIV / AIDS			
Kidney Disease			
Liver Disease / Gall Bladder			
Lung Disease			
Lupus			
Mitral Valve Prolapse			
Other Auto-Immune Disorders			
Neurological Disorder			
Parkinson's Disease			
Psychological Disorder			
Seizure / Epilepsy			
Stroke			

SOCIAL HISTORY	RESPONSE
Occupation (If Retired please indicate former occupation)	
Alcohol History	Oz per Week____ # Years Since Quit_____ NEVER
Smoking History	# per Day____ # years ____ # Years Since Quit_____ NEVER
Illicit Drug History- LIST	
List any Pets that you have	
Who Referred you to Dr. Wegman?	

PATRICK A WEGMAN MD
DERMATOLGY

Patient's Name ____ **Birth Date _______________**

YOUR FINANCIAL RESPONSIBILITIES

I understand that as a courtesy to me, Dr. Wegman may bill my claim to my insurance company according to the rules or policies of my insurance company. I authorize my insurance company to send their determination and/or payment of my insurance claim directly to Dr. Wegman. I understand that Dr. Wegman participates with most Blue Cross policies, Medicare, several HMO's and other commercial insurance companies. If my insurance company requires a referral from my primary physician to process my claim, I understand that it is my responsibility to obtain the referral. If I do not obtain a referral, I agree to be responsible for payment of the claim. If I have an insurance with which Dr. Wegman does not contract, or I do not have insurance, my signature on this form indicates my acceptance of my financial responsibility for the charges for my visit. I authorize Dr. Wegman to release any personal, medical, and/or financial information (including alcohol, drug abuse, mental health, HIV, AIDS & AIDS related complex treatment) related to my care, to my insurance carrier(s) or persons/agency responsible for the processing of my medical claim.

I understand that for my best medical care Dr. Wegman prefers to do a complete skin evaluation. During my evaluations, Dr. Wegman may diagnose skin conditions that he considers to be medically necessary or advisable to treat today. The treatment of these conditions will be billed separately from the office call to my insurance company according to general coding guidelines. Diagnosis of some conditions may require a KOH, which is a scraping of the skin that Dr. Wegman will examine under the microscope. Certain wounds require treatment with special surgical dressings and/or debridement that will also be billed separately to my insurance company. Cryotherapy, is the application of Liquid Nitrogen, which is an extremely cold substance used to freeze/burn lesions or growths on the skin. Your insurance company may call this procedure a "surgery" on your explanation of benefits. If an area treated today does not resolve, your insurance will be charged for whatever treatment is necessary when you return. Some conditions require more than one treatment. Each time you are treated with Liquid Nitrogen, your insurance company will be billed. Any of these above medically necessary procedures that are performed today will be billed to my insurance in accordance with coding guidelines and insurance regulations.

I understand that I will receive a statement from Dr. Wegman's office if a balance remains after my insurance company processes my claim and determines that I am responsible for a co-pay, co-insurance, deductible or any other amount that my insurance company approves but does not pay to Dr. Wegman. This unpaid balance will remain my responsibility until it is paid. I agree to be responsible for any balance my insurance company determines I am responsible for and does not pay to Dr. Wegman. Dr. Wegman offers several methods of paying my balance due. I may mail my payment, bring it to the office, or call and have the balance or a partial payment applied to my credit card. If the check I use to make payment from my bank account has insufficient funds, I will be charged any bank fees that Dr. Wegman incurs as a result of the transaction. When possible, my deductible and copay will be determined prior to my visit. The office may call me to ask that I bring my office call copay and/or approximately $150 of my deductible to my appointment. These payments will be applied to any charges processed but not paid by my insurance company. If I am experiencing a financial hardship a CareCredit application can be submitted at my appointment. In addition, I may set up a payment plan. If I have any questions regarding my charges or remaining balance I may ask to speak to the Billing Specialist. I understand that Dr. Wegman charges a no-show fee for any missed appointments. I understand that Dr. Wegman charges a no-show fee for any missed appointments. If I no show an appointment, I may be charged: $ 75 (for return patient visit), $ 100 (for a new patient visit), or $ 150 (for procedure appointments). No show fees can be avoided if you give the office at least 24 hours' notice to cancel an appointment. We understand that emergencies arise sometimes so if you have to cancel your appointment within 24 hours, please call the office and the no show fee may be waived. I have been made aware and agree to the financial responsibilities and insurance information stated above. I permit a copy of this authorization to be used in place of the original. This authorization is valid until I provide Dr. Wegman with written revocation.

SIGNED____ **DATE____________________**

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Patrick Wegman for any services furnished to me by him or his office staff at his direction. I authorize any holder of my personal medical records to release to the Health Care Financing Administration, or its agents, any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. This authorization is valid until I provide Dr. Wegman with written revocation.

SIGNED____ **DATE____________________**

PATRICK A WEGMAN MD
DERMATOLOGY

Name ____ **Date of Birth** ______________ **Today's Date** _____________________

GENERAL CONSENT FORM AND PRIVACY PRACTICES

The protection of your identity and the privacy of your personal medical information is very important to our office. To comply with new government rulings we are required to verify your identity at each appointment by asking you for a photo ID and your insurance card. In addition, your identity must be confirmed when you call with questions regarding your condition, prescription refills, requesting or cancelling an appointment, and account demographic changes.

The following information will assist us in your care and in our communications with you, while protecting your confidentiality.

1. **RECORDS:** Your signature below indicates that you authorize Dr. Wegman to retrieve any data, films, records, slides, medical records, and laboratory or pathology reports from other providers/labs to assist in your treatment.
2. **RISK:** Your signature below indicates that in the event that Dr. Wegman or any of his employees is exposed to your blood or body fluids, you have been informed that an HIV antibody test may be performed on you. (Public Act 488).
3. **CONTACT:** Your signature below indicates that you authorize Dr. Wegman to contact, leave a message on your home answering machine, and/or mail to you, your spouse, or a minor's parent, at your home address information regarding your medical condition, your account statement, appointment information, or insurance items.
4. **PHOTOGRAPHS:** Your condition may need to be photographed by Dr Wegman for educational/scientific/medical record purposes. Your signature also indicates you have been informed that any pictures taken will remain the property of Dr. Wegman. If your pictures are used for education or research, you will **NOT** be identified by name.
   [Example: a picture of your mole, cancer site, or unusual skin condition**]**
5. **MEDICATION HISTORY:** My signature below gives my permission for Dr. Wegman or his representative to obtain a list of all of my current and previous medications from my pharmacy or from a website that stores all medications my insurance company has processed.
   My local pharmacy is _________________________ I have a prescription insurance card **Yes** **No**

   My mail order pharmacy is (if applicable) _______________________________
6. **PATIENT PORTAL, DIRECT MESSAGING, & REGISTRY REPORTING:** Your signature below indicates that you understand that the Affordable Care Act has required that physician's offices share information with you, your other physicians, and regulatory registries electronically. Please be assured that this is **always** done in a secure or encrypted method. Some reports to regulatory registries may require statistical information from your encounter but your name will not be included.
7. **HIPAA:** My signature below indicates that I have received and/or reviewed or have declined to receive and/or review a copy of Dr. Wegman's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). My signature allows Dr. Wegman to keep this information in my medical chart. A separate Privacy Practices Acknowledgement Form may be reviewed and signed at my request.

Because of the importance of each of these notifications, if I do not sign this form, Dr. Wegman may need to decline to provide my dermatologic care. This form is valid indefinitely or until I provide written revocation.

____
Signature of Patient/Parent/Guardian **Date**

____
Signature of Employee Witness **Date**

PATRICK A WEGMAN MD
DERMATOLOGY

CONSENT FOR MINOR DERMATOLOGIC DIAGNOSTIC OR SURGICAL PROCEDURES

I understand that for my best medical care Dr. Wegman prefers to do a complete skin evaluation. During this evaluation, Dr. Wegman may diagnose skin conditions that he considers to be medically necessary or advisable to treat today. The treatment of these conditions will be billed separately from the office call to my insurance company according to general coding guidelines. Diagnosis of some conditions may require a KOH, which is a scraping of the skin that Dr. Wegman will examine under the microscope. Certain wounds require treatment with special surgical dressings and/or debridement that will also be billed separately to my insurance company. Any procedure provided to treat a medically necessary condition will be billed to my insurance.

Conditions that are not medically necessary to treat, such as Seborrheic Keratoses, Milia, Skin Tags, etc., may be noted by Dr. Wegman during your exam. Depending on the amount of time available in your appointment he may treat these areas at your request and at his discretion. Procedures provided to treat a condition that is not medically necessary will not be charged to your insurance and will be your personal responsibility when the appointment is scheduled specifically for the treatment of that condition and you have been provided with an estimate of your out of pocket charges.

Cryotherapy, is the application of Liquid Nitrogen, which is an extremely cold substance used to freeze/burn lesions or growths on the skin. Your insurance company may call this procedure a “surgery” on your explanation of benefits. If an area treated today does not resolve your insurance will be charged for whatever treatment is necessary when you return. Most Warts require more than one treatment and the appointment will be scheduled today. When you return for treatment of your Warts your insurance company will be billed again. These are correct billing procedures according to coding guidelines.
By signing below, I indicate that Dr. Wegman or his representative has discussed the above treatment or procedure with me and has explained the information that is briefly summarized below:

1. The nature, purpose, and intended outcome of the recommended treatment or procedure.
2. The risks and possible complications of the recommended procedure. I am aware that in addition to the specific risks of the treatment or procedure explained to me, as in any procedure, there are other risks such as infection, scar tissue, poor healing process, minimal blood loss.
3. The prognosis (medical prediction) if the treatment or procedure is refused.

I understand that the practice of medicine and surgery is not an exact science, and that no guarantees have been made concerning the results of any procedure. I feel I have had sufficient opportunity to discuss my condition with Dr. Wegman and/or his staff and all of my questions have been answered to my satisfaction.

- **I believe that I have adequate knowledge and understanding upon which to base an informed consent to the treatment or procedure.**
- **I understand and authorize that my insurance will be charged for an office call and for any medically necessary diagnostic or treatment procedures performed today.**
- **I also understand that I may be responsible for any charges that are approved but not paid by my insurance such as my deductible, copay, and co-insurance.**
- **My signature is valid for one year from the date signed unless I provide written revocation.**

If you have questions regarding the fees for treatment please ask to speak to our biller.

____ ____
Signature of Patient, Parent, or Guardian Date Print Name of Patient Date of Birth/Age

____, Signature of Witnessing Employee ______________, Date

NAME:_________________________ **PATRICK A WEGMAN MD** DATE:___________

DERMATOLOGY

Pharmacy:_______________________

MEDICATION & ALLERGY INVENTOY

(We will copy list if you prepare one)

(Includes Prescriptions, OTC, & Supplements)

ALLERGIES:

____

____

____

ADVERSE DRUG REACTIONS:

____

____

____

MEDICATION NAME	DOSAGE	FREQUENCY

____

Patient Name **Date of Birth**

REVIEWED BY:

DATE: