WESTERN DERMATOLOGY CONSULTANTS, P.C.

REGISTRATION FORM

THE INFORMATION REQUESTED ON THIS FORM IS USED TO FILE MEDICAL CLAIMS AND FOR OTHER IMPORTANT MEDICAL DOCUMENTATION. PLEASE PRINT LEGIBLY SO THAT WE MAY ACCURATELY REFLECT YOUR PERSONAL INFORMATION IN ANY TRANSACTION WE MAY NEED TO MAKE ON YOUR BEHALF. THIS INCLUDES CALLING YOUR INSURANCE COMPANY, SENDING REQUISITIONS TO LABS, etc.
THANK YOU

Referring or Primary Care Physician: (**FIRST AND LAST NAME**)

PATIENT INFORMATION

Patient's last name:	First:	Middle Int:	❑ 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? **THIS IS REQUIRED FOR FILING AN INSURANCE CLAIM***	Preferred/Nickname:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:

City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )	Home phone no.: ( )	Cell phone no.: ( )

INSURANCE INFORMATION

PLEASE PROVIDE RECEPTIONIST WITH YOUR INSURANCE CARD(S)

Please indicate **primary** insurance company name:			
Subscriber's name: ***REQUIRED*** **This is the person who carries the policy.**	Subscriber's S.S.#:	D.O.B.: ***REQUIRED***	****IN ORDER FOR THE WDC TO FILE A CLAIM ON YOUR BEHALF, THE INFORMATION ASKED HERE IS REQUIRED. WITHOUT THIS INFO, WE WILL NOT BE ABLE TO BILL YOUR INSURANCE COMPANY, MAKING YOU A SELF PAY PATIENT****
		/ /	

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of **secondary** insurance (if applicable):	Subscriber's name:	D.O.B.: / /	

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Person responsible for bill: ***REQUIRED***	D.O.B.: ***REQUIRED*** / /	Address (if different):	Home phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Western Dermatology Consultants, P.C. or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Allergic To: ________________ ________________ ________________

Patient Name: ______________________________ Date: ____________

1. What type of skin problem are you having? ______________________________

2. How long have you had this problem? ______________________________

3. Where did this problem start on your body? ______________________________

4. Has it spread? ______________________________
5. What type of Symptoms are you having from this? ______________________________

6. What, if anything, makes it better or worse? ______________________________

7. What, if any, treatment has been tried for this problem? ______________________________

8. Have you ever had a similar problem to this before? ______________________________

9. Is there a family history of the same or similar problem? ______________________________

10. What medications are you taking? Please include over-the-counter medications, vitamins, herbal remedies/treatments.

11. Are you allergic to any medications or medical products? If so, please list below.

12. Is this problem a rash? If yes, please answer the questions below:
    a. Have you used any new soaps, lotions, skin care products or laundry detergents prior to its onset?
       ❑ Yes ❑ No
    b. Are any of your medications new, i.e. started 1-2 months before the rash?
       ❑ Yes ❑ No
    c. Do you have a history of asthma, allergies (seasonal), hay fever, sinus problems, psoriases, lupus, rheumatoid arthritis?
       If so, which one(s)? ______________________________
    d. Is there a family history of asthma, allergies (seasonal), hay fever, sinus problems, psoriases, lupus, rheumatoid arthritis?
       If so, which one(s)? ______________________________

BRIEF MEDICAL HISTORY

Do you have a history of skin cancer? ❑ Yes ❑ No Type of Cancer: ______________________________

Is there a family history of skin cancer? ❑ Yes ❑ No Relationship: ______________________________

Past Surgeries: ______________________________

Do you require antibiotics before dental care? ❑ Yes ❑ No Do you smoke? ❑ Yes ❑ No

Have you had problems in the past with local anesthesia? ❑ Yes ❑ No

Please circle any conditions for which you have been treated:

Angina	Heart Surgery	Pacemaker
Burns/Grafted Skin	Herpes Cold Sores	Radiation Therapy
Chemotherapy	High Blood Pressure	Steroid Therapy
Diabetes	Keloid Scars	Thyroid Disease

How would you describe your skin?

Always Burns, Never Tans	Sometime Burns, Always Tans
Always Burns, Sometimes Tans	Never Burns, Always Tans

For Women of Child Bearing Age: Are you pregnant or think you might be? ❑ Yes ❑ No

Do you use birth control method? ❑ Yes ❑ No If yes, which one: ______________________________

Date of last menstrual period: ______________________________