WEXLER DERMATOLOGY

PATIENT INFORMATION FORM

This PATIENT INFORMATION FORM is part of your Medical Record and must be completed in its entirety

☐ **PATRICIA WEXLER, M.D.** ☐ **FRANCESCA FUSCO, M.D.** ☐ **KEN HOWE, M.D.** ☐ **EUGENE WEXLER, M.D.**

Patient: _____ Date: ____/____/_____
Last Name First Name Middle Name

SS#: _____ Date of Birth: _____ Age: ___ Sex: F M Marital Status: S M D W

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Email: _____ Occupation: _____

Employer Name: _____ Work Address: _____

Referred By: ☐ Social Media _____ ☐ Friend _____ ☐ Dr. _____

Primary Care Physician: _____ Office #: _____

Office Address: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Pharmacy Name: _____ Pharmacy #: _____

RESPONSIBLE PARTY (IF MINOR)

Person Responsible for Payment: _____
Last Name First Name Middle Name

Relationship to Patient: _____ SS#: _____ Date of Birth: _____

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Email: _____ Occupation: _____

Employer Name: _____ Work Address: _____

CONSENT FOR PHOTOGRAPHY

I hereby give my permission to my physician or any assistant that he/she may designate to take photographs for diagnostic purposes and to enhance the medical record. I agree that these photographs will remain his/her property and he/she may use them for medical, scientific, or other presentations and publications.

Patient Name (print): _____

Signature: _____ Date: _____

WEXLER DERMATOLOGY

PATIENT INFORMATION FORM

The practice financial policy will be given to patients at the time of registration all patients must sign this form.

OUR PRACTICE FINANCIAL POLICY

The physicians and staff at our practice are dedicated to providing you with the best possible care and service. We regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policies. If you have any questions, please feel free to discuss them with our staff.

PAYMENT IS EXPECTED AT THE TIME OF TREATMENT. WE WILL PROVIDE YOU WITH A FORM TO PRESENT TO YOUR INSURANCE CARRIER (IF APPLICABLE). WE ACCEPT CASH, PERSONAL CHECKS, DEBIT CARDS AND CREDIT CARDS (MASTERCARD, VISA, DISCOVER, AND AMERICAN EXPRESS)

Cancellation Policy/ Not Keeping Appointment. All patients will be charged a fee for appointments not cancelled within 48 hours prior to the date of their appointment.

MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

PATHOLOGY AND LABORATORY FEES

Pathology and laboratory fees are separate from our fees and will be billed directly to you.

You will receive a separate bill from the lab company.

In the event of credit card dispute or arbitration, you agree to give Wexler Dermatology, P.C., permission to release any pertinent medical information from your records.

I have read, understand, and agree to the financial policies of this office. I am fully responsible for all professional fees and services rendered.

Signature: _____

Parent/Guardian (if minor): _____ Date: _____

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Have you ever had:

YES NO

____ ____ Have you previously had a skin problem or been under the care of a dermatologist?

If yes, please describe:

_____

_____

____ ____ Do you take any medicines, drugs, over-the-counter preparations, vitamins or herbal remedies?

If yes, please list:

_____

_____

____ ____ Are you allergic to any medicines, drugs, latex, over-the-counter preparations or herbal remedies?

If yes, please list:

_____

_____

Prior hospitalizations and surgery (please give approximate dates):

_____

_____

THE DERMATOLOGICAL EXAMINATION, WHICH YOU ARE ABOUT TO RECEIVE, IS NOT A COMPLETE PHYSICAL EXAMINATION. IT IS SUGGESTED THAT YOU HAVE A COMPLETE PHYSICAL EXAMINATION PERIODICALLY BY YOUR FAMILY PHYSICIAN OR INTERNIST.

I certify that I have read and filled out the patient registration and medical history form fully and correctly to the best of my knowledge, and that the information that I have supplied is complete and correct. I understand that withholding medical information could lead to complications or problems that may have been prevented if that information were known prior to my care and treatment.

Signature: _____ Date: _____

Please add any additional information which you feel may assist the doctor in your care:

_____

_____

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MEDICAL HISTORY (CHECK ALL THAT APPLY)

YES	NO	
____	____	DUDODENAL OR PEPTIC ULCER
____	____	OTHER INTESTINAL DISEASE OR COLITIS
____	____	LIVER OR GALLBLADDER DISEASE
____	____	HEART DISEASE (RHEUMATIC FEVER, PACKEMAKER, OTHER)
____	____	HIGH BLOOD PRESSURE
____	____	STROKE
____	____	KIDNEY DISEASE
____	____	URINARY OR BLADDER PROBLEM OR INFECTION
____	____	HEPATITIS A, B OR C
____	____	HERPES SIMPLEX
____	____	VENEREAL DISEASE
____	____	BLOOD OR LYMPH GLAND DISORDER
____	____	EYE DISEASE (GLAUCOMA, CATARACT, OTHER)
____	____	THROMOPHLEBITIS
____	____	CANCER
____	____	FREQUENT INFECTIONS (SKIN OR OTHER)
____	____	NEUROLOGICAL DISORDER
____	____	EMOTIONAL OR PSYCHIATRIC PROBLEM
____	____	EXCESSIVE BLEEDING WHEN CUT
____	____	DIFFICULTY WITH THE HEALING OF WOUNDS
____	____	OVERGROWN SCARS OR KELOIDS
____	____	ALLERGY TO LOCAL ANESTHETICS
____	____	HAVE YOU HAD VAGINAL YEAST INFECTIONS?
____	____	ARE PREGNANT?
____	____	ARE YOU CURRENTLY PLANNING A PREGNANCY?

Please inform the doctor at any time if you plan to or become pregnant during your treatment period.

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Have you or any members of your family (specify who) had:

YES	NO	
____	____	ASTHMA
____	____	HAYFEVER
____	____	ECZEMA
____	____	HIVES
____	____	DIABETES
____	____	PSORIASIS
____	____	SKIN CANCER
____	____	GLAUCOMA
____	____	OTHER SKIN CONDITIONS

(SPECIFY)

_____

_____

SOCIAL HISTORY

YES	NO	
____	____	Do you drink alcohol? If yes, ____drinks per day
____	____	Do you use recreational drugs? If yes, what?_____ how much? _____
____	____	Do you smoke? If yes, how much? _____

Any conditions not listed above:

_____

_____

_____

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PATIENT ACKNOWLEDGEMENT OF DISCLOSURE INFORMATION

My signature below acknowledges the following:

- I have received a copy/am aware of the Patient Bill of Rights; as required by law and have had an opportunity to receive assistance in understanding and exercising these rights.
- I have received a copy/am aware of this office's Notice of Privacy Practices, including the Private Health Information (Pill) designated at the time of visit.
- I have received information on/am aware of the Speak up Program Campaign.
- I have received information on/am aware of the Infection Control measures utilized by this organization.
- I have received information on/am aware of the safety measures taken by this organization when a procedure is planned.
- I am aware of the Informed Consent for my procedure and will read and understand how that affects me. All my questions have been answered to my satisfaction.
- I have received a copy/am aware of the Practice Disclosure (about our Practice, including the Grievance process) and am comfortable with that information. I also understand this practices position on Do Not Resuscitate (DNR) and Living Wills and that this practice does not honor these directives.
- I have received information regarding the infection control process of this organization and I understand this information.

Signature of Patient/Representative:

_____

Date:

_____

Above signature was not obtained because:

☐ Patient is unable and unaccompanied by a representative. Patient left with all pertinent disclosures

☐ Patient refused to sign.

☐ Patient refused forms.