John K. Wildemore MD, LLC
Dermatology & Dermatologic Surgery

Welcome to Our Office – Please Complete the Following Patient Registration Information

Last Name _____ First _____ M.I. _____

Date of Birth ____/____/____ Gender: M F Preferred Language _____

Marital Status (circle): Single Married Domestic Partner Divorced Widowed

As required by Medicare: **Race:** White African American Asian Native American Other **Ethnicity:** Hispanic Latino Neither Refuse to Report

Mailing Address _____

City _____ State _____ Zip Code _____

E-mail Address _____

Occupation _____ Employer _____

I was referred by _____

Primary Care Physician Name & Phone Number _____

Pharmacy Name _____ Location _____

To respect your privacy, please list only phone numbers where we may call AND leave messages:

Home _____ Cell _____

Emergency Contact _____ Relationship _____ Phone # _____

Do you give permission to discuss your confidential medical information with a family member or other person? **YES NO**

(IF YES, please provide information below and phone number where message can be left.)

Name _____ Phone number _____ Relationship _____

An insurance card will be required at each visit if you would like us to bill your participating insurance plan(s).

***IF YOU ARE NOT THE RESPONSIBLE PARTY (i.e., you are insured under the plan of a spouse/parent) please list Guarantor information below:**

Last Name _____ *First* _____ *M.I* _____

Mailing Address _____

City _____ *State* _____ *Zip Code* _____

Telephone Number: Home: _____ *Cell:* _____

Relationship to Patient (circle one): Parent Spouse Other

The above is true and correct to the best of my knowledge: *(If under age 18, signature of parent or guardian)*

Signature _____ Date _____

744 W. Lancaster Avenue, Suite 230 ● Wayne PA 19087
Phone: 610-688-8750 ● Fax: 610-688-8751

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Medical History

Last Name_____First _____M.I.____Date of Birth: ____/____/____Today's Date___/___/___

Past Medical History: Please Circle Any Past or Present Medical Conditions

Cancer: Type_____		Asthma	Artificial joints
High blood pressure	Depression	Kidney disease	Liver disease
Heart disease	HIV	Hepatitis	Pacemaker/other heart device
Artificial heart valve	GI/Stomach problems	Bleeding Disorder	
Thyroid disease : Hypo Hyper		Diabetes: Type1 Type 2	

Other Conditions_____

General Review of Systems:

Do you have a history of any of the following? (If YES, please circle):

Difficulty healing Formation of keloid scars Excessive bleeding Allergic reaction to tape/bandage

Have you recently experienced any of the following? (If YES, please circle):

Fever/Weight Loss	Infection	Difficulty Breathing	Vision Problems
Psychiatric Problems	Urination Problems	Joint/Muscle Pain	Chest Pain/Palpitations
Abdominal Pain	Neurological Problems	Other:_____	

Surgeries/hospitalizations (list details):_____

_____

Have you ever had a skin cancer? **YES** **NO**

IF YES, please describe:_____

Is there a family history of skin cancer? **YES** **NO**

IF YES, please describe:_____

Medications: Please list all medications you are currently taking (including supplements and over-the-counter):

_____

_____

_____

Allergies: Are you allergic to any medications? **YES** **NO** (If YES, please list):

_____

Are you currently pregnant or lactating? **YES** **NO** If yes, please specify: _____

Do you smoke tobacco of any kind? **YES** **NO** If yes, how often?_____/packs a day

The above is true and correct to the best of my knowledge: *(If under age 18, signature of parent or guardian)*

Signature_____Date_____

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Practice Policies and Consents

Financial Policy: We make every effort to provide the finest dermatologic care. We appreciate your assistance in facilitating payment to ensure we can continue to do so. Payment is due in full at the time of service, including insurance co-payments, co-insurance and unmet deductible portions when applicable. **Please note that although a service may be 'covered' by your insurance plan, depending on any deductible, co-payment or co-insurance due, you may be responsible for all or part of the 'covered' amount.** We cannot predict what your plan may or may not require you to pay, as every insurance policy has different coverage, deductible and co-insurance specifications – these are determined by your employer and insurance plan. It is your responsibility to be aware of any referral requirements, restrictions, limitations and requirements of your policy, including whether any 'out-of-network' restrictions apply.

Dermatology Billing Associates is our billing service. They process billing according to your insurance company's policies. Should a balance be due, Dermatology Billing Associates will issue a statement. Please note that ultimately you are fully responsible for all fees charged regardless of your insurance coverage. Any unpaid balances 90 days past due will be sent to a collection agency – any and all fees associated with the collection process (including the collection agency's commission) will then be added to the total balance due.

In addition, please note the following policies:

- **If we are unable to confirm your insurance coverage at the time of your visit, payment in full may be required at the time of service.**
- **Patients requiring a referral are responsible for obtaining referrals prior to the appointment. Unfortunately, we cannot do this for you. If there is no referral at the time of your appointment, you may have to reschedule your appointment or be responsible for full payment.**
- **Biopsy and surgical specimens are sent to an outside lab for examination – the lab will bill you and your insurance separately for their services.**
- **Missed appointments or those cancelled with less than 24 hours' notice may be assessed a $75 cancellation fee.**
- **Checks returned by your bank are subject to a $35 processing fee.**
- **We are participating providers with Medicare and accept assignment on all medically necessary claims. Medicare patients are responsible for meeting their annual deductible and paying the 20% co-payment. Our billing service will file with secondary/supplemental carriers. However, if the secondary does not pay within 60 days, patients will be billed the remaining balance.**

Consents:

1. **Financial Policy:** I hereby certify that I have read, understand and agree to abide by the above financial policies. I understand that I am financially responsible for non-covered services, deductibles, and/ or co-payments.
2. **Assignment of Benefits:** I authorize the release of medical information as necessary to process any insurance claims and I also direct payment of any insurance benefits to John K. Wildemore, M.D., LLC for services rendered.
3. **Referrals:** I understand that it is my responsibility to obtain any referral form(s) from my Primary Care Physician required by my insurance. If I have not obtained these form(s) I will be responsible for payment in full if the insurance company rejects payment.
4. **Medical Treatment & Photographs:** I consent to examination, performance of tests & procedures and medical photographs during the course of my care in the practice of John K. Wildemore, M.D., LLC, by the physician and/or his or her assistants.
5. **Release of Medical Information:** I authorize John K. Wildemore, M.D., LLC to furnish my primary care physician, referring physician, and any other medical professionals involved in my care with any health information necessary regarding my physical/mental condition and/or any treatments/conditions associated with my care. I also authorize the release of medical information as necessary to my insurance company and associated institutions/agencies for payment of benefits.
6. **Receipt of HIPAA Notice of Privacy Practices:** I have had the opportunity to review a copy of this practice's HIPAA Notice of Privacy Practices and all of my questions have been answered to my satisfaction. By signing below, I consent to the use and disclosure of my protected health information for treatment, payment and health care operations. I understand that the terms of the Notice may change, and if they do, a revised copy may be obtained by contacting the office. I understand I have the right to revoke this consent in writing. However, such a revocation shall not affect any disclosures that have already been made in reliance on my prior consent

My signature below indicates that I have read, understand, and agree to and consent to all of the above statements. My authorization shall remain in force until revoked in writing by the undersigned.

Patient Signature (parent/guardian if patient under 18)_____**Date**_____

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