Weill Cornell Medicine
Dermatology

Please Note: All information is confidential and will become part of your medical record
Do not leave any boxes empty, mark N/A for not applicable or None if appropriate. **PLEASE PRINT CLEARLY**.

<table>
<tr><td colspan="2">***Patient Name:***</td><td colspan="2">***Date of Visit:***</td></tr>
<tr><td colspan="2">***Date of Birth:***</td><td colspan="2">**Social Security Number:**</td></tr>
<tr><td>***Gender***
❑ Male ❑ Female</td><td colspan="3">**Marital Status:**
❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Domestic Partner</td></tr>
<tr><td colspan="2">***Home Address:***</td><td colspan="2">***Home Phone#:***

Other Phone#:</td></tr>
<tr><td colspan="2">***Preferred Email Address:***</td><td colspan="2">**Emergency Contact (Name and Phone Number):**

Relationship to Patient:</td></tr>
<tr><td colspan="2">**PRIMARY INSURANCE CARRIER:**</td><td colspan="2">**INSURANCE ID #:**</td></tr>
<tr><td colspan="2">**INSURANCE PHONE #:**</td><td colspan="2">**Are you the Primary Insurance policy holder?**
❑ Yes ❑ No</td></tr>
<tr><td colspan="4">**If No, Please list the Name and Date of Birth of the Policy Holder:**</td></tr>
<tr><td colspan="2">**Does your insurance plan require referrals for specialty visits?** ❑ Yes ❑ No</td><td colspan="2">**If YES, do you have a referral for today's visit?**
❑ Yes ❑ No</td></tr>
<tr><td colspan="2">**SECONDARY INSURANCE CARRIER:** ❑ N/A</td><td colspan="2">**INSURANCE ID #:**</td></tr>
<tr><td colspan="4">**Physician and Pharmacy Information**</td></tr>
<tr><td colspan="4">**Referring Physician** (Name/Phone/ Fax Number):

Were you referred by the above mentioned physician for a Consultation? ❑ Yes ❑ No</td></tr>
<tr><td colspan="4">**Primary Care Provider** (Name/Phone/Fax Number)**:** ❑ **Same as Referring?**</td></tr>
<tr><td colspan="4">**Preferred Pharmacy** (Name/Phone/Fax Number)**:**</td></tr>
</table>

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I certify that all information above is true and correct. I authorize the holder of medical information about me to release to my insurance and, if I am a Medicare patient, to the Centers for Medicare and Medicaid Services and its agents, any information necessary to determine these benefits or the benefits payable for related services. I request that payment of any benefits be made on my behalf to the provider of services. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for payment in full for these services including any amounts not paid by my insurance carrier such as Copayments, Deductibles, and other Non-covered services.

I understand that cosmetic and other non-medically necessary services are not covered by my insurance carrier and that I will be financially responsible for any such non-covered services at the time of the visit.

__________________________________ ____________________
Patient Signature **Date**

WCMC Department of Dermatology – Patient Exam Questionnaire

Patient Name: ________________________________ **Patient Date of Birth**

Why are you here today? **(Please list)**

1. ________________________________ 3. ________________________________

2. ________________________________ 4. ________________________________

Please answer each of the following questions by checking off the appropriate box. Fill in explanation when necessary.

SOCIAL HISTORY

Do you smoke? ☐ NO ☐ YES How much? __________________

Do you drink? ☐ NO ☐ YES How much? __________________

Do you use IV drugs? ☐ NO ☐ YES

Have you had or have you been exposed to HIV (AIDS)? ☐ NO ☐ YES

ALLERGIES

Has your doctor ever requested you take antibiotics before a dental procedure? ☐ NO ☐YES

Are you **allergic** to any of the following?

Penicillin ☐ NO ☐ YES ____________________ **Sulfa** ☐ NO ☐ YES __________________

Any other drugs? ☐ NO ☐ YES If **yes** what?________________________________

If yes, what type of reaction did you have?________________________________

Any foods? ☐ NO ☐ YES If **yes**, what?________________________________

Nail polish/cosmetics? ☐ NO ☐ YES If **yes**, what?________________________________

SKIN

Have you ever had a skin biopsy? ☐ NO ☐ YES If yes, when?____________Biopsy Site?_______________

Have you ever had skin cancer? ☐ NO ☐ YES If yes, what type? ________________________________

Any other form of cancer? ☐ NO ☐ YES If yes, what type?________________________________

Any abnormal skin moles? ☐ NO ☐ YES If yes, where? ________________________________

Do you have a history of any skin diseases? ☐ NO ☐ YES If yes, what?________________________________

Do you bleed easily? ☐ NO ☐ YES

Do you develop keloid scars? ☐ NO ☐ YES

Has any one in your family ever had skin cancer? ☐ NO ☐ YES If yes, who? _____________What type?_____________

MEDICINES

Are you taking any medications (prescriptions, over-the-counter) regularly now? ☐ NO ☐ YES

If **yes**, fill out the following:

Name of medication	Reason for taking this

OPERATIONS AND HOSPITALIZATIONS

Have you ever been hospitalized? ☐ NO ☐ YES

If **yes**, fill out the following:

Date of hospitalization	Reason for hospitalization

SYSTEMS REVIEW

Do you have any of the following complaints?

GENERAL

Fatigue ☐ NO ☐ YES
Weight loss ☐ NO ☐ YES
Weakness ☐ NO ☐ YES
Swollen Lymph nodes ☐ NO ☐ YES
Easy bruising ☐ NO ☐ YES

HEAD

Visual problems ☐ NO ☐ YES
Ear pain, decreased hearing ☐ NO ☐ YES
Difficulty swallowing ☐ NO ☐ YES
Severe headaches ☐ NO ☐ YES
Strokes ☐ NO ☐ YES
Other ________________________________

MEN ONLY

Hair growth or loss ☐ NO ☐ YES
Discharge from penis ☐ NO ☐ YES
Sore on penis ☐ NO ☐ YES
Other ________________________________

CHEST, HEART AND LUNGS

Shortness of breath ☐ NO ☐ YES
Chest pain or pressure attacks ☐ NO ☐ YES
Frequent cough ☐ NO ☐ YES
Swollen ankles ☐ NO ☐ YES
Valve disorder ☐ NO ☐ YES
Other ________________________________
____

GASTROINTESTINAL

Poor appetite ☐ NO ☐ YES
Indigestion or vomiting ☐ NO ☐ YES
Change in bowel habits ☐ NO ☐ YES
Pass blood from rectum ☐ NO ☐ YES
Other ________________________________

ENDOCRINE

Thyroid condition ☐ NO ☐ YES
Diabetes ☐ NO ☐ YES
Other ☐ NO ☐ YES________________________

GENITALIA (WOMEN ONLY)

Breast lump ☐ NO ☐ YES
Discharge from nipple ☐ NO ☐ YES
Vaginal discharge or spotting ☐ NO ☐ YES
(not from period)
hot flashes ☐ NO ☐ YES
Change in periods ☐ NO ☐ YES
Are your periods irregular? ☐ NO ☐ YES
Possibly pregnant ☐ NO ☐ YES
Number of times pregnant ______________
Number of children ______________

KIDNEY

Difficulty in passing urine ☐ NO ☐ YES
Getting up at night to urinate ☐ NO ☐ YES
Other ________________________________

NEUROMUSCULAR

Weakness in arms or legs ☐ NO ☐ YES
Dizzy spells ☐ NO ☐ YES
Fainting spells ☐ NO ☐ YES
Other ________________________________
____

BONES/JOINTS

Painful or swollen ankles ☐ NO ☐ YES
Loss of muscle strength ☐ NO ☐ YES
Prosthetic bone replacements ☐ NO ☐ YES
Back pain ☐ NO ☐ YES
Other ________________________________

ANY OTHER PROBLEMS OR CONCERNS? (PLEASE DESCRIBE)

____
____
____
____

____ ____________________
Physician's Signature **Date**

Weill Cornell Medicine
Dermatology

Patient Name: ____

MRN#: ____________________________

The following is our Payment Policy which we require you to read and sign prior to your visit(s).

Thank you for choosing WCM- Dermatology to provide your health care. We are committed to your successful treatment.

You are required to inform us immediately of any changes in demographic (home address, telephone numbers) Or medical insurance information.
You are expected to pay all previous outstanding balances prior to scheduling the next visit.
If you have questions about billing, please ask to speak with one of our Billing Representatives or call 646-962-4521.

If we are participating providers:
You must present your Insurance Card, and, if applicable, Insurance Referral Forms at every visit. We will submit bills directly to your insurance company for payment on your behalf. Patients without insurance card(s) and/or a proper referral will be asked for payment in full at time of service or to reschedule the visit.
It is the patient's responsibility to obtain new and up to date Insurance Referrals, if applicable.
All co-pays, deductibles and non-covered services will be collected at time of service. In the event that your insurance coverage changes to a plan where we are not participating providers, please refer to the below section.

We are legally required to collect your copayments, coinsurance and or deductibles:
The Healthcare Financing Administration (otherwise known as HCFA) is the federal government agency responsible for setting policy and overseeing the Medicare/Medicaid programs. HCFA has mandated that physicians and other providers of care Must Collect Copayments, Coinsurance and Deductibles. This is enforced by the Office of Inspector General (OIG). The reasoning behind this is that if your doctor waives your copayment or deductible he/she is in effect giving you a discount. Therefore if he/she is willing to provide this service to you at a discount, he should also give a discount to the Insurer. The second reason is that the insurers objective for requiring copayments and deductibles is to cause you (the insured), to have a shared cost of your healthcare, thereby reducing unnecessary consumption of covered services.
We understand that sometimes financial hardships may affect your ability to pay in full. We will always do everything we can to work with you. However we ask that you contact us as soon as possible to discuss an arrangement that is satisfactory for everyone.

If we are Out of Network with your insurance plan Or You do not have medical insurance:
Payment is due at time of service. It is the responsibility of the patients to submit an original claim directly to their insurance company along with any pertinent information/documents.

Cosmetic Services
Payment in full is due at the time of service for all services that are considered not medically necessary or cosmetic. No Exceptions.

Usual and Customary Rates
Your insurance policy is a contract between you and your insurance company. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

We appreciate your faith and trust in us and thank you for the opportunity to serve your healthcare needs.

I authorize payments to be made directly to the Weill Cornell Medicine- Department of Dermatology and fully understand that I am the responsible party for all charges incurred by me or my dependents at this facility. I also authorize the release of any and all information required to collect and process my medical insurance claims.

I have read the policy; I understand and agree to it.

____
Print Name of Patient or Responsible Party

____ ________________________
Signature of Patient or Responsible Party *Today's Date*