the Dermatology Clinic PLLC
Dr. Angela Wingfield • Dr. Ashley Emerson

11295 E Taylor Rd. | Gulfport, MS 39503 228-864-3300
6510 Hwy 90, Suite C | Gautier, MS 39553 228-372-8559
TheDermClinic.net 228-864-3333

Chart # _____

We welcome you and thank you for selecting The Dermatology Clinic, PLLC for your healthcare needs. We are dedicated to providing you with the best possible healthcare. To help us, please fill out this form completely in ink. If you have any questions, please ask us. We will be happy to assist you.

1. Personal Information

Patients' Name (Mr. / Mrs. / Ms. / Dr.) _____
Date of Birth _____ / _____ / _____
Patient Mailing Address _____
City / State / Zip _____
☐ Male ☐ Female Social Security # _____ - _____ - _____
Race _____ Ethnicity _____ Preferred Language _____
☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Employer _____ Occupation _____
Email _____

2. Telephone Information

Home Phone _____ Work Phone _____ Cellular Phone _____
In the event of an emergency, who should we contact?
Name _____ Relationship _____ Phone _____

3. Responsible Party (If not Patient)

Who is Responsible for the Account? _____
Address / City / State / Zip _____
Relationship to Patient _____ Social Security # _____ - _____ - _____
Date of Birth _____ / _____ / _____
Employer _____ Occupation _____
Work Phone _____ Home Phone _____

4. Insurance Information

Primary Insurance

Name of Insured _____
Relationship to Patient _____
Insured's Birth date _____ / _____ / _____
Social Security # _____ - _____ - _____
Employer _____
Insurance Co. _____
Employee I.D. / Cert.# _____
Group # _____

Secondary Insurance

Name of Insured _____
Relationship to Patient _____
Insured's Birth date _____ / _____ / _____
Social Security # _____ - _____ - _____
Employer _____
Insurance Co. _____
Employee I.D. / Cert.# _____
Group # _____

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5. No Show/ Cancellation Policy

The Dermatology Clinic, PLLC requires a 24 hour cancellation notice for all scheduled appointments. **If you do not cancel 24 hours prior to your scheduled appointment, you will be charged a $50.00 cancellation / no show fee.This fee is not reimbursable by insurance and will be due at the time of your next visit.**

6. Additional Charges from Outside Facilities

If you have a biopsy performed, wound culture swabbed, or lab work drawn, there will be an additional charge billed to you and / or your insurance company directly from the lab for performing the test

7. Authorization and Release (please sign below)

☐ I authorize the release of any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care, to third party payers and / or other health practitioners.

☐ I authorize and request my insurance company to pay directly to the doctor, insurance benefits otherwise payable to me.

☐ I understand that my insurance carrier may pay less than the actual bill for the services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Medicare Patients:

☐ I request the payment of authorized benefits be made to the Dermatology Clinic, PLLC on my behalf for any services furnished to me by the provider.

☐ I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

X _____ _____ / _____ / _____

Signature of Patient (or Parent if Minor) Date

_____

Printed Name of Patient

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Patient Questionnaire

Please answer the following questions (please print)

Name _____ DOB ____ /_____ /_____ Today's Date ____ /_____ /_____

Reason for today's visit _____

How long have you had this problem? _____

List any previous treatment for the problem _____

Please list all allergies (medication or other) _____

List all **medications** you are currently taking (over-the-counter meds; vitamins and herbals / dosage and frequency)

Have you ever had dental anesthesia (Novocaine)? ☐ Yes ☐ No Any bad reaction? ☐ Yes ☐ No

Do you have a pacemaker / defibrillator? ☐ Yes ☐ No

List all surgical procedures and year performed (within the last 10 years) _____

Do you smoke? ☐ Yes ☐ Never ☐ Former Start Date ____ /_____ /_____ End Date ____ /_____ /_____

Do you drink alcohol? ☐ Never ☐ Occasionally ☐ Frequently

Are you pregnant? ☐ Yes ☐ No Breastfeeding? ☐ Yes ☐ No

What is your occupation (or past occupation if retired)? _____

Please check any of the following problems **you** might have or had:

Skin
- ☐ Keloids
- ☐ Poor healing
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Other _____

Hematologic / Lymphatic
- ☐ Anemia
- ☐ Bleeding problems
- ☐ Enlarged lymph nodes
- ☐ Blood clots / DVT

General Symptoms
- ☐ Weight loss
- ☐ Fever
- ☐ Weak, tired
- ☐ Nausea, vomiting, diarrhea (when taking antibiotics)

Ears / Eyes / Nose / Throat
- ☐ Glaucoma
- ☐ Hearing aid
- ☐ Cosmetic surgery
- ☐ Other _____

Cardiovascular
- ☐ Angina, heart attacks
- ☐ Heart valve problems
- ☐ High blood pressure

Respiratory
- ☐ Asthma
- ☐ Emphysema
- ☐ Other lung problems
- ☐ Allergies

Gastrointestinal
- ☐ Stomach ulcers
- ☐ Other GI problems

Musculoskeletal
- ☐ Arthritis
- ☐ Artificial joints
- ☐ Aching joints
- ☐ Other _____

Neurological
- ☐ Stroke
- ☐ Seizures
- ☐ Other _____

Psychiatric
- ☐ Depression
- ☐ Anxiety attacks
- ☐ Other _____

Endocrine
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Other _____

Infections
- ☐ Hepatitis ____ Type / treatment
- ☐ Urinary tract
- ☐ HIV / AIDS ☐ Staph ☐ TB

Please check if **family member** has had any of these diseases and list family member.
- ☐ Melanoma (skin cancer); Family member _____
- ☐ Other skin cancer; Family member _____
- ☐ Seasonal allergies; Family member _____
- ☐ Psoriasis; Family member _____
- ☐ Eczema; Family member _____
- ☐ Acne; Family member _____
- ☐ Other _____

Have you had extensive sun exposure? (even as a child) ☐ Yes ☐ No

Have you had blistering sunburns? (even as a child) ☐ Yes ☐ No

Do you have a history of skin cancer? ☐ Yes ☐ No Type _____

If yes, please list **site, date, treatment and doctor** _____

Please list any other cancers or malignancies _____

Primary Care Physician _____

Do we have your consent to communicate with your primary care physician? ☐ Yes ☐ No

Preferred Pharmacy _____

Patient Signature _____

Signed by Physician _____ **Reviewed by** _____

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Financial Policy

Patient Name _____ Date of Birth _____ / _____ / _____

Your clear understanding of our financial policy is important to our professional relationship.

- Our financial policy requires that payment in full be collected on the day that services are rendered unless the service is covered by insurance.
- If you have valid health insurance coverage with one of the insurance carriers that we contract with, we will collect co-pays at the time of service(s) being rendered. The co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier.
- You are also responsible for any co-insurance, deductibles or non-covered services as required by your insurance.
- After payment is received from your insurance carrier(s), any balance that remains on the account will be deemed your responsibility including balances of insurance responsibilities not paid within 60 days from the date of service.
- You will be notified on your first statement from our billing office of the balance which is due and payable upon receipt of the statement.

Please select one of two options for paying account balances.

☐ If payment is not received within 30 days of the first statement issued, there will be an additional $5 statement fee added to each statement that is processed and mailed until the balance is paid in full.

☐ **Provide credit card information and sign credit card authorization in the office to ensure that the balance will be paid in a timely fashion to avoid any additional statement fees.

- **We will NOT call you prior to charging your card, so consider this if you give us your debit card number. You may incur overdraft charges at your bank.**
- **You have the right to dispute any charges which you feel may be incorrect. You still have the right to question your insurance company's determination of payment.**

☐ I have read and acknowledge the Financial Policy of The Dermatology Clinic, PLLC.

X _____ _____ / _____ / _____

Signature of Patient (or Parent if Minor) **Date**

**To be filled out and signed in office:

☐ I authorize The Dermatology Clinic, PLLC to charge the remaining balances on my account after insurance has paid to the following credit card after 30 days from the date of my mailed statement.

☐ Visa ☐ MasterCard ☐ American Express ☐ Care Credit ☐ Discover

Account Number _____ Expiration Date _____ CVV _____

Name as it appears on the card (please print) _____

Signature _____ **Date** _____ / _____ / _____

Email to send credit card receipt _____

(Please print clearly)

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Patient Notice of Privacy Policy Acknowledgement

Patient Name _____ DOB _____ / _____ / _____

I acknowledge that I have been given an opportunity to review The Dermatology Clinic, PLLC's Notice of Privacy Practices, which is displayed in the lobby and will be provided a copy if I desire one. In order to assist The Dermatology Clinic, PLLC in protecting my privacy, I have answered the following questions on how the clinic may disclose my medical information.

☐ Yes ☐ No You may call me on these numbers:
Home _____ Cell _____ Work _____
Leave messages on my answering machine / voicemail:
☐ Home ☐ Cell ☐ Work
Send appointment reminders to: ☐ Home ☐ Cell

☐ Yes ☐ No Text Message Reminders (if reminders are sent to a cell phone)

☐ Yes ☐ No You may leave messages regarding my care with the following persons:

Name _____ Relationship _____
Phone # _____
Name _____ Relationship _____
Phone # _____

☐ Yes ☐ No You may photograph my skin for documentation purposes.

X _____ _____ / _____ / _____
Signature of Patient (or Legal Guardian) Date

_____
Legal Guardian's Name (Please Print)