

BARRY C. WEINER, MD ALL-COUNTY DERMATOLOGY

PATIENT REGISTRATION FORM

DATE: _____

PATIENT NAME		TITLE Mr. Mrs. Ms. Miss		Jr. Sr.
ADDRESS		CITY	STATE	ZIP CODE
DATE OF BIRTH		AGE	SEX	
HOME PHONE	CELL PHONE	WORK PHONE		
EMAIL ADDRESS		PATIENT'S SOCIAL SECURITY NUMBER		
PATIENT'S EMPLOYER NAME and ADDRESS				
POLICY HOLDER		RELATIONSHIP TO PATIENT	DATE OF BIRTH	
POLICY HOLDER'S EMPLOYER NAME and ADDRESS		POLICY HOLDER'S BUSINESS PHONE	POLICY HOLDER'S SSN	
EMERGENCY CONTACT - NAME		RELATIONSHIP TO PATIENT	PHONE NUMBER	
IF STUDENT:	Full Time	Part Time	NAME OF SCHOOL: _____	
HOW DID YOU HEAR ABOUT THIS OFFICE?				
NAME OF PHYSICIAN WHO REFERRED YOU HERE _____				
NAME OF FRIEND/RELATIVE WHO REFERRED YOU HERE _____				
ATTENDED LECTURE / SKIN CANCER SCREENING				
YELLOW PAGES (specify) Ocean County Freehold Red Bank Other _____				
TELEPHONE, WRITTEN and FAX COMMUNICATION				
DO WE HAVE PERMISSION TO:				
Leave a detailed message on your answering machine at home?		YES	NO	
Leave a detailed message at your place of employment?		YES	NO	
Fax information to you?		YES	NO	If yes, please indicate fax number _____
Discuss your medical condition with any member of your household?		YES	NO	
If yes, whom: _____ Relationship: _____ Last 4 digits of SSN (req) _____				
Mail information to your home address work address?				
PATIENT SIGNATURE (if minor parent or guardian) _____				DATE: _____
NAME and TELEPHONE NUMBER OF YOUR PHARMACY				
PRIMARY MEDICAL INSURANCE COMPANY and ADDRESS			POLICY NUMBER / GROUP NUMBER	
OTHER INSURANCE			POLICY NUMBER / GROUP NUMBER	

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Dermatology Medical History

PATIENT NAME: _____ DATE: _____

REASON FOR TODAY'S VISIT: _____

IF YOU ARE HERE FOR A SPECIFIC LESION, HOW LONG HAVE YOU HAD THE LESION? _____

HAS THIS LESION CHANGED? IF SO, HOW? _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? 1) _____ 2) _____ 3) _____ 4) _____

HAVE YOU EVER HAD NOVOCAINE? Yes No ANY BAD REACTION? Yes No

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS, VITAMINS, HERBALS, ETC.)

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

DO YOU HAVE NOW, OR HAVE YOU EVER HAD DISEASES OR CONDITIONS OF: (PLEASE CIRCLE YES OR NO)

LUNGS	YES	NO	OTHER SYSTEMIC	YES	NO
Bronchitis			Diabetes		
Emphysema			Excessive Thirst / Hunger		
Asthma			Thyroid		
Chronic Cough			Kidney		
Morning Cough			Liver		
Shortness of Breath			Eyes		
Wheezing			Cancer		

CARDIOVASCULAR	YES	NO	BLADDER	YES	NO
High Blood Pressure			Frequency / Burning		
High Cholesterol					
Chest Pain					
Heart Attack					
Heart Murmur					
Irregular Heartbeat					
Phlebitis					
Inflammation of vein					
Blood Clots					
Pacemaker					

GASTROINTESTINAL
Stomach absorptive disorder
GI sensitivity with antibiotics
Yeast infection with antibiotics

Arthritis / Joint Deformity
Arthralgias
Limited Motion
Artificial joint
Convulsion, Epilepsy, Seizures
Fainting

LIST ANY OTHER DISEASES OR CONDITIONS: _____

LIST ANY SURGICAL PROCEDURES YOU HAVE HAD: _____

SKIN

HAVE YOU EVER HAD SKIN CANCER? YES / NO IF YES, WHICH TYPE? _____

HAS ANY BLOOD RELATIVE HAD SKIN CANCER? YES / NO IF YES, WHICH TYPE? _____

Skin (continued):

DO YOU HAVE A HISTORY OF ANY SPECIFIC SKIN DISEASES: YES / NO IF YES, WHICH TYPE: _____

DO YOU HAVE PROBLEMS WITH HEALING? YES / NO

DO YOU DEVELOP KELOIDS (OVERGROWN SCARS) AFTER SURGERY? YES / NO

DO YOU BLEED EASILY? YES / NO

DO YOU DEVELOP SKIN RASHES IN REACTION TO: MEDICATION / FOOD / ENVIRONMENT

IF SO, PLEASE DESCRIBE _____

DID YOU SPEND A LOT OF TIME IN THE SUN AS A YOUTH? YES / NO

DO YOU CURRENTLY SPEND A LOT OF TIME IN THE SUN? YES / NO

DO YOU USE SUN PROTECTION? YES / NO IF YES, WHAT SPF? _____

SOCIAL HISTORY

DO YOU DRINK ALCOHOL? YES / NO IF YES, SOCIALLY / _____ DRINKS DAILY

DO YOU USE IV DRUGS? YES / NO IF YES, WHAT? _____ HOW OFTEN? _____

DO YOU SMOKE? YES / NO IF YES, HOW MANY PACKS DAILY? _____

DO YOU HAVE OR HAVE YOU BEEN EXPOSED TO HIV (AIDS)? YES / NO

WHAT IS YOUR OCCUPATION? _____ HOBBIES? _____

WOMEN ONLY

ARE YOU PREGNANT? YES / NO DUE DATE: _____

ARE YOU CURRENTLY PLANNING A PREGNANCY? YES / NO

ARE YOU TAKING BIRTH CONTROL PILLS? YES / NO

DO YOU HAVE A REGULAR MENSTRAL CYCLE? YES / NO IF NOT, DESCRIBE: _____

DO YOU GROW HAIR ON THE LIP / CHIN / BELLY BUTTON / BREAST AREAS / NONE

PATIENT SIGNATURE: _____
PARENT OR GUARDIAN IF PATIENT IS A MINOR

MEDICAL ASSISTANT _____ INITIALS _____ REVIEWED BY _____ DATE _____

200 White Road, Ste 109
Little Silver, NJ 07739

BARRY C. WEINER, MD

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ALL-COUNTY DERMATOLOGY FINANCIAL POLICY

This outline was designed to help patients better understand the financial policy of All-County Dermatology. By having a clear understanding of your financial obligations and the procedures to follow, you can help us keep our billing and collection costs down, which will be reflected in our lower fees for services. Patients basically fall into one of two broad categories of payment, 1) insurance patients and 2) cash patients.

Insurance Patients: All-County Dermatology participates in many insurance plans and we agree to accept what these insurance companies allow as payment in full. What patients must keep in mind; however, is that what the insurance company allows is not always what the insurance company pays. Many times, patients are responsible for co-payments, coinsurances and deductibles. **Copayments** are payments made by the patient at the time of the office visit. **Coinsurances** are amounts that the patient must pay to supplement the amount paid by the insurance company. Coinsurances are usually expressed as a percentage; for example, a patient has a coinsurance of 20%. **Deductibles** are a certain amount of money which the patient must pay out-of-pocket before their insurance company begins to pay the medical bills. At All-County Dermatology, co-payments are due at the time of the visit. If it can be determined at the time of the visit how much a patient's coinsurance or deductible is, the patient will be expected to pay these portions of the bill at the time of the visit. If coinsurances and deductibles cannot be determined until after notification from the insurance company, the patient will be billed for these amounts. Prompt payment of these bills is appreciated. There are some special circumstances which insurance patients must consider: 1) In the event that the insurance company sends you a check for payment instead of sending payment to the office, we expect patients to endorse the check(s) and send them to the office. These checks should not be cashed by the patient. 2) Although we participate in many insurance plans, certain services and procedures are considered "medically necessary" or "uncovered services" by insurance companies. Two examples of this are the removal of skin tags and sclerotherapy (injection of spider veins). In these cases, patients must pay for services at the time they are rendered. 3) Despite our best efforts, occasionally an insurance company does not pay for services rendered in the time period specified by our contract. If the insurance company does not pay the bill within 90 days of submission of a correct claim, the patient will be responsible for the bill. In these cases, we will provide you with any necessary documentation to assist you in obtaining reimbursement from your insurance company. This includes cases in which the insurance company or other third party payors file for bankruptcy. 4) Any changes in insurance must be reported to our office so that we may correctly bill for the visit. If a patient does not inform us of changes, the patient will be held responsible for payment.

I authorize use of this form or a copy of it on all my insurance submissions. **I authorize** the release of information to all my insurance companies. **I authorize** my insurance benefits to be paid directly to the physician.

Cash Patients: Cash patients are patients who have no insurance or who have insurance plans in which the patient pays the physician first and is then reimbursed by the insurance company. These patients must pay for services at the time of the visit. We accept cash, check, Visa and Master Card.

I, _____, have read and understand the above financial policy of All-County Dermatology. I agree to the terms outlined above and accept full responsibility for any financial obligations I may have. I understand I will be responsible for all costs and charges relative to collection with a maximum charge of 25% of the balance.

Signature _____ Date _____
(if minor, parent or guardian must sign)

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Cosmetic Interest Questionnaire

(Patient Optional)

Name: _____

Address: _____

Telephone: _____

Please email me information on special offers and events! Yes No

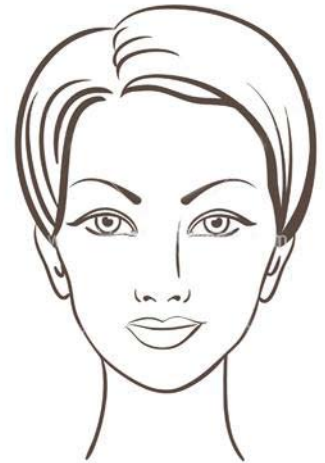
E-mail address _____

THESE ARE THE AREAS OF CONCERN FOR ME

- Fine Lines and Wrinkles
- Frown Lines between the brows
- Wrinkles / Lines around nose and mouth
- Length / Thickness of eyelashes
- Texture of skin / Pore Size
- Facials and Eye treatments
- Facial Veins
- Spider Vein Treatment
- Hair Removal
- Removing Leg Veins
- Age Spots / Liver Spots
- Birthmarks
- Skin Care Products
- Skin Care Advice
- Sagging / Loose skin
- Uneven Skin tone
- Acne
- Unwanted hair
- Dark Circles under eyes
- Freckles / Sun Damage
- Dryness
- Other _____

RANKING OF CONCERNS

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____



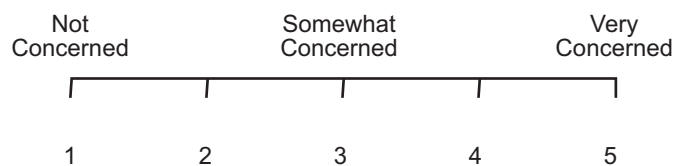
Please feel free to print out and mark areas of concern on the facial diagram

OTHER COMMENTS

When looking at my face in the mirror, I believe I look younger, the same as or older than my true age.



When looking in the mirror, I am not concerned, somewhat concerned or very concerned about the appearance of my wrinkles



Signature _____

BARRY C. WEINER, MD

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HOWELL, NJ 07731

Phone (732) 363-0100

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CONSENT FOR DISCLOSURE OF PATIENT INFORMATION PRIVACY PRACTICES ACKNOWLEDGEMENT

The Privacy Rule that is contained in HIPPA (Health Insurance Portability Accountability Act) establishes a federal requirement that health care providers obtain a patient's written consent before using or disclosing the patient's personal health information to carry out treatment, payment, or health care operations (TPO). This must be obtained before information may be used or disclosed for TPO purposes, except in emergency situations.

The following information must be included in a medical record release form used by the Practice to be in compliance with HIPPA requirements.

I understand that by giving consent I am permitting my personal health information to be disclosed to persons who will be involved in my treatment; it may also be used for payment and operational purposes. I have the right to review the provider's "notice of privacy practices" before I sign this consent. The provider reserves the right to change the terms of the notice of privacy practices. Changes in the privacy practices will be made available to me. I may request additional restrictions on access to this information for treatment, payment or health care operations purposes. I understand that the provider may not be able to comply with this request. I request the following special restriction(s): _____.

I understand that from time to time my physician and his/her staff may inform me of new drugs, treatments, or other services that may be appropriate for my condition and from time to time may inform me of new services that may be appropriate for a person in my situation (age, sex, etc.). I consent to the use of my identifiable patient information to notify me of such new drugs, treatments, or other services that may be necessary for the continuity of my care or which may be of benefit in maintaining or improving my health with the understanding that the provider will not provide such information to others for marketing, fund-raising, or similar purposes without my specific consent.

I understand the Practice may condition receipt of treatment upon the execution of this consent.

I understand that I, or my representative, upon request, may inspect, request correction of and obtain information from my medical record, **in accord with your office policies.**

I may revoke this consent in writing at any time except to the extent that the provider has already acted in reliance on this consent.

Patient Name: _____

(please print)

Signature _____ Date _____

(if minor, parent or guardian)