Warren Skin Care Center

755 MEMORIAL PKWY # 204 PHILLIPSBURG, NJ 08865
2209 LEHIGH STREET EASTON, PA 18042

PATIENT INFORMATION FORM- PLEASE PRINT

Name: _____ **Date of Birth**___/___/____
Full legal: FIRST NAME—LAST NAME mm /dd / yyyy

SSN #_____

Address: _____
City_____ **State**_____ **Zip**_____

Home Tel#_____ **Cell #**_____

Work # _____ **E-Mail Address**_____

Pharmacy Name _____ **Zip**_____ **Tel**_____

Gender: ☐ Male ☐ Female **Marital Status (Circle One):** S M D W Sep

I can be reached at the following phone number_____

If I am not there, you can share the information with:

Name: _____ **relationship:** _____

Name: _____ **relationship:** _____

Race (Circle One): Decline, Caucasian, Black or African American, Asian, Indian, Native Hawaiian or Pacific Islander, Other

Ethnicity (Circle One): Decline, Hispanic or Latino, Asian, Indian, Not Hispanic or Latino

Language: English, Spanish, Other_____

If under 18, Parent/Guardian: _____
Guardian SSN# _____
Emergency contact: _____
Relation: _____ **Tel#**_____
Primary Care Physician: _____ **Tel#**_____

Primary Insurance Name: _____
Subscriber/Insured: _____ **Relation to patient:** _____
Insured Date of Birth: _____ **Insured SSN#**_____

Secondary Insurance Name:_____
Subscriber/Insured:_____ **Relation to patient:**_____
Insured Date of Birth:_____ **Insured SSN#**_____

I certify that the above information is true statement _____
Signature patient/legal representative/Guardian

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RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM I hereby acknowledge that on _____ I received the Notice of Privacy Practices from Warren Skin Care Center, which sets forth the ways in which my personal health information may be used or disclosed by Warren Skin Care Center Physicians, and outlines my rights with respect to such information.

Signature:_____ Date:_____

Consent Form

Warren Skin Care Center

I. **Authorization for Treatment**

I, patient/patient's legal representative, agree to permit performance of such diagnostic, evaluation and therapeutic procedures that the physician(s) deems necessary for my treatment and care.

II. **Authorization to Release Information**

I authorize the physician(s) and any of their agents to release information as may be necessary for the completion of claims for reimbursement to the appropriate healthcare insurer, agency or any third party which may be liable for all or part of the charges generated for services rendered. I further understand that such information will be available to other health care entities as may be necessary for the completion of claims for reimbursement to the appropriate health care insurer, agency or any third party which may be liable for charges.

III. **Assignment of Benefits**

In consideration of services received, I assign the benefits payable for services rendered to the physician(s) or designated agents. I direct those insurers to pay such benefits directly to the physician(s) or designated agents. I agree to pay any and all fees that exceed or that are not covered by my insurance coverage and waive any and all notices and demands in the event of non-payment. This assignment and authorization is valid from the date of signature, unless revoked by written notice to the physician(s) or their agents. This notice must be received prior to release of information.

IV. **Medicare/TRICARE/Champus Payment/NOPP**

I certify that the information I gave if applying for payment under Title XVII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim (including TRICARE/Champus/Humana Military Claims). I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician(s) or their designated agents. I am aware that if I am choosing to utilize a health care provider that is not in network with my insurance plan, I accept responsibility for the out of network penalty determined by my insurance company. The policy of managed care insurance plans states that all services must be prescribed or authorized by your Primary Care Physician in order for payment to be made by the insurance company. If you obtain specialty service without a referral from your insurance company, you will be responsible for any charges associated with this visit.. If you have not obtained such a referral, you may reschedule this visit after obtaining a referral or sign below, stating your financial responsibility for all services received during this visit. In the event that some services are not covered by your insurance, and if you elect to receive these services, you will be responsible for the charges associated with your visit. I accept responsibility for any charges associated with this visit.

Signature patient/legal representative/Guardian	Relationship	Date

Andrew L.J. Li, MD

Date: _____ **Name:** _____ **Referring Physician:** _____

Date of Birth: _____ **Height:** _____ **Weight:** _____

What are your main reasons for today's visit?

1) _____

2) _____

3) _____

Present Illness: Location (what part of the body) _____

Symptoms (itching, burning, pain) _____

Severity (mild, persistent, moderate, severe) _____

Timing (rapid or gradual onset) _____

Improving or worsening (or enlarging) _____

Does your condition change in relation to sun exposure, hobby, work, stress, foods, etc.? _____

Is your condition better or worse with medications? _____

Associated symptoms (fatigue or loss of sleep) _____

Treatment? _____

Review of Systems /Any other problems? (please circle appropriate answer(s)): Disorders of skin, hair, or nails, Discomfort of mouth or nose, Swelling, Fever, Chills, Night sweats, Fatigue, Loss of Weight/ Appetite, Nausea or Vomiting, Headaches, Change in vision, Tension/Anxiety, Feeling down, depressed or hopeless, Lost interest in doing things, Joint pain, Nerve tingling/pain/numbness, Muscle weakness, Chest pain, Breathing difficulties (nasal stuffiness, cough, wheezing), Stomach or Bowel problems, Bleeding or bruising, Lymph node enlargements, Swollen ankles, Sensitive to hot or cold, Difficulty urinating

1.Your past medical history and social history:

☐ Skin cancers ☐ High Blood ☐ Artificial Heart Valves ☐ Diabetes Pressure ☐ Artificial Joints ☐ Seizure ☐ Defibrillator ☐ Bleeding Disorder ☐ Heart Trouble ☐ Hepatitis ☐ Rheumatic Fever ☐ Pacemaker ☐ HIV ☐None

Major surgery and hospitalizations:

_____

_____

2. Family history (Circle answer(s)):

Have any diseases been diagnosed in your family (i.e., Skin cancers including basal cell carcinoma, Squamous cell carcinoma or melanoma, psoriasis, eczema, hay fever, arthritis, abnormal moles, asthma, high blood pressure, diabetes)?

3. Social history: Smoking Yes ☐ No ☐ | Or Alcohol (more than 2 drinks/day) Yes ☐ No ☐

Current occupation/hobbies: _____

4. Medications: What medications or supplements are you currently taking? Aspirin, Ibuprofen, Ecotrin, Aleve, Vitamin E, Coumadin, Plavix _____

_____

_____

_____

_____

5. Allergies to Medication/Food/Environmental

_____

_____