

DERMATOLOGY ASSOCIATES OF WESTERN CONNECTICUT, P.C.

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(203) 792-4151 (203)792-4155

www.dermwestconn.com

APPOINTMENT DATE: _____

WELCOME

PLEASE PRINT CLEARLY

1 Patient Personal Information

First Name: _____ Middle: _____ Last Name: _____ Jr/Sr _____

Title: Mr ___ Mrs ___ Miss ___ Marital Status: (S) ___ (M) ___ (W) ___ (D) ___ Email _____

Age: _____ Date of Birth: ____/____/____ Social Security Number: ____/____/____

Male ___ Female ___ Student? (Y) ___ (N) ___ If student, name of school: _____

Street Address: _____ P.O. Box : _____

City, State, Zip Code: _____ City, State, Zip Code: _____

Patient's Employer: _____ Parent/Guardian Employer: _____

Spouse's Name: _____ Spouse's Employer: _____

Full name of the person who referred you? _____ Physician ___ Friend ___ Relative ___ Self ___

Who is your Primary Care Doctor? _____ Their phone number: _____

Primary Care Physician's Address: _____

2 Telephone

Home # _____ Work # _____ Cell # _____

I prefer to receive phone calls at ___ Home ___ Work

I give DAWC my permission to: ___ Leave a message on my answering machine / ___ Leave a message at work

I give DAWC permission to contact the following person(s) regarding my medical condition, lab results, or financial information:

_____/ Relationship _____

_____/ Relationship _____

In case of EMERGENCY, please call : _____/ Relationship _____

Name of Pharmacy: _____ Telephone # _____ CityCT _____

3 Primary Insurance Info

Insurance Company Name: _____

Policyholder's Name: _____ Relationship to Patient: Self ___ Spouse ___ Guardian/Other: ___

Birthdate: _____ Driver's License #: _____ Social Security #: _____

Address of Policyholder _____

City, State, Zip: _____

Employer Name: _____ If unemployed, check here: _____

Work Phone: _____ Home Phone: _____

Please let the front desk know if you have a separate card for prescription coverage. Please go to 2nd page.

4 Secondary Insurance (if applicable)

Insurance Company Name: _____	Policyholder's Name: _____
Policyholder's relationship to the patient: Self _____ Spouse _____ Other _____	Policyholder's Date of Birth: _____
Policyholder's Social Security Number: _____/_____/_____	Policyholder's Home Phone # _____
Policyholder's Address: _____	Policyholder's Work/Cell # _____
_____	Policyholder's Employer _____

5 Payment Policy

Please read carefully!

We accept VISA, MASTERCARD, AMEX, DISCOVER, CASH AND CHECKS.

For HMO, PPO, Medicare or other managed care insurance plans: You will be responsible for paying any deductibles, coinsurance, copays and charges for any non-covered cosmetic services. **Payment of copays is required at the time of service. A \$10.00 surcharge will be charged to any patient that does not pay the copay at the time services are rendered.** Co-insurance and deductibles will be billed to you and are due upon receipt of one bill.

For Private Insurance Patients: Patients who are covered by private commercial plans in which our physicians are not providers will be required to pay the total bill at the time of service. An insurance claim form will be mailed to you to use for submission of the bill to your insurance carrier.

For Patients with No Insurance: Full payment is required at the time of service.

For Cosmetic Or Any Medically Un-necessary Procedures: Full payment is required at the time of service.

6 Authorization, Release & Confidentiality

My signature below authorizes any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or any carrier, any information needed for this or a related Medicare or other insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand that DAWC may, at times, send me emails promoting health education and/or in-office promotions. I may request in writing that I do not want to receive any such emails from DAWC. Further, my signature indicates that I understand and accept the financial policy described above. All therapeutic communications, records, and contacts with the Dermatology Associates of Western Connecticut staff will be held in strict confidence in accordance with the Health Insurance Portability & Accountability Act (HIPAA). I can request my medical records in writing via mail or FAX. If I have any questions, your staff is trained to assist me.

Our Notice of Privacy Practice (NPP) provides information about how we may use and disclose protected health information (PHI) about you. It discusses your rights as a patient and Dermatology Associates of Western Connecticut's duties with respect to your PHI. You have the right to review our policy before signing this acknowledgement. If we change our Notice you may obtain a revised copy by contacting our office or from our website: www.dermwestconn.com. Your signature acknowledges your receipt of our NPP. Your signature also acknowledges your receipt of our prescription refill policy.

..... Signature of patient or legal guardian

Date

Did you remember to sign this form?!
Did you know that you can refill your prescriptions online at our website?
Visit www.dermwestconn.com

Optional Cosmetic Questionnaire

Patient Name: _____ Date: _____

Reason for your visit today: _____

I am interested in learning more about (choose all that apply):

- Botox
- Fillers (Collagen, Restylane, Perlane, Juvederm, Radiesse, Sculptra)
- Laser Hair Removal
- Laser Treatment of blood vessels or brown spots
- Chemical Peels (superficial and deeper)
- Microdermabrasion
- Photofacials (intense pulsed light)
- Sclerotherapy (removal of spider veins on the legs)
- Acne treatments
- Wrinkle treatments
- Treatment of Birthmarks
- Laser Tattoo Removal
- Skin Care Products

Please answer the following two questions on a scale of 1 to 5 by circling the appropriate number.

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

Younger Than		True Age		Older Than
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of fine lines and wrinkles.

Not Concerned		Somewhat Concerned		Very Concerned
1	2	3	4	5

Would you be interested in a free consultation with our Medical Aesthetician to discuss our facial treatment offerings? ____Yes ____No