Dermatology Medical History

Patient: _____ Date of Birth: ___/___/_____ Today's Date: __/___/___

Reason for today's visit: _____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Chronic Cold Sores
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Hysterectomy: Uterine Cancer
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed, (Right, Left, Bilateral)
Hysterectomy: Fibroids
None
Other _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratosis
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None
Other: _____

Do you wear sunscreen? Yes No If yes, what SPF? ____
Do you tan in a tanning salon? Yes No
Do you have a family history of Melanoma? Yes NO
If yes, which family relative(s)? _____
Any other Family history? _____

Medications: (Please enter all current medications)

_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____

Social History: (please circle all that apply)

Cigarette Smoking:
- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Sexual History:
- Not sexually active
- Sexually active with one partner
- Sexually active with more than one partner
- Same sex partner

Illicit Drug Use:
- Drug Use
- IV Drug Use

Alcohol Use:
- None
- Less than 1 drink a day
- 2-3 drinks a day
- 3 or more drinks a day

Safety:
- I feel safe at home
- I do not feel safe at home

Exercise:
- Several times a day
- Once a day
- Few times a week
- Few times a month
- Never

Caffeine Use:
- Several times a day
- Once a day
- Few times a week
- Few times a month
- Never

First Degree Relative Medical History: (Parents, Siblings or Children)

- Anxiety
- Arthritis
- Asthma
- Atrial fibrillation
- BPH
- Bone Marrow Transplantation
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD
- Hearing Loss
- Chronic Cold Sores
- Hepatitis
- Hypertension
- HIV/AIDS
- Hypercholesterolemia
- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- Smoker
- Valve Replacement
- None

Other_____

Medicare Patient Information

Patient Name: _____ SSN: _____
Last First MI

Date of Birth: ____/____/____ Sex: ❑ Female ❑ Male

Race: _____ Ethnicity: _____

Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Address: _____
Street

_____
City State Zip Code

_____ _____ _____
Home Phone Work Phone Cell Phone

_____

Please print your name as it appears on your Medicare card.

_____

Medicare Health Insurance Claim Number as it appears on your card. This is usually your Social Security number. Be sure to include the letter after the nine-digit number. (It is important that we have both the numbers and letter)

Emergency Contact

Name of Spouse or Close Relative or Friend: _____
(In Case of Emergency)

Phone# ( ) _____

Primary Care Physician

Name: _____ Phone# ( ) _____
Last Name First Name

Preferred Pharmacy _____ Phone# ( ) _____
Name and Location

Please Sign So We May Have Your Medicare Authorization On File

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare 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. Regulations pertaining to Medicare assignment of benefits apply.

Date: ____/____/____ Signature: _____

-Continued on Back-

Payment Policy

Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual $140.00 deductible and paying for the 20% copayment. We do file with secondary /supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.

Are you in a Medicare HMO or other Senior Medicare Plan? ❑ Yes ❑ No

If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers.

Name of Plan: _____

Policy Number: _____ Group #: _____

Name Policy Holder (Insured):_____ ❑ Male ❑ Female

Date of Birth: ____/____/____

Supplemental (MEDIGAP) Insurance

In the event of a major procedure or hospitalization, we request secondary insurance information for our records (supplemental Medicare insurance information). Please fill out below if you are covered by a plan which covers the 20% NOT covered by Medicare. (MEDIGAP Coverage)

Name of Insurance Company: _____

Policy Number: _____ Group #: _____

Name Policy Holder (Insured):_____ ❑ Male ❑ Female

Date of Birth: ____/____/____

Please Sign So We May Have Your Supplemental Authorization On File:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Date: ____/____/____ Signature: _____

WARMUTH
INSTITUTE OF DERMATOLOGY
MEDICAL • SURGICAL • COSMETIC

420 Front Street
Elmer, NJ 08318

4 Bypass Road Suite 104
Salem, NJ 08079

95 Woodstown Road
Swedesboro, NJ 08085

856.358.1500 • 856.358.1117 (fax)
www.warmuthinstitute.com

Cancelation Policy

When you make an appointment with one of our providers, we set aside an appointment time specifically for you. If you miss an appointment, it can't be filled by another patient in need of our services. Therefore, any missed or canceled appointments within 24 hours will result in a $50.00 charge to be billed directly to the patient. ____ (please initial)

Thank you in advanced for your cooperation in this matter, and we look forward to providing you with the utmost in medical care.

Patient or Responsible Party Signature_____ Date___/____/_____

Receipt of Notice of Privacy Practice:

My signature below indicates that I have received and/or reviewed a copy of my physicians Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices).

Patient or Responsible Party Signature_____ Date___/____/_____

Biopsy Results:

Please put the names of any person(s), that we will be able to discuss your medical information with.

I hereby give permission for the providers of Ingrid P. Warmuth, MD PA to discuss my biopsy results from all dates of service with the following people:

Name	***Birth Date***	***Telephone***

_____

Signature **Date**

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Cosmetic Skin Care Form

Thank you for choosing Dr. Ingrid Warmuth Skin Care Center for your skin care needs. Our office provides high quality care and our philosophy is to actively listen to your needs and offer you the best care possible. In order to help us provide that care, please assist us by completing this form.

Name: _____ Email: _____

1. Describe your skin type: ❍ Normal ❍ Oily ❍ Dry ❍ Combination ❍ Sensitive
2. What skin care products are you currently using? _____

   _____
3. Do you experience any allergic reactions to any skin care products? ❍ No ❍ Yes

   _____
4. Are you interested in learning about:

   ❍ Botox/Dysport/Xeomin ❍ Fillers ❍ Chemical Peels ❍ Laser/Light Treatment
   ❍ Microdermabrasion ❍ Any Resurfacing Treatment ❍ Anti-Aging Treatments
   ❍ Skin Care ❍ Facials ❍ Makeup ❍ Acne Treatments
5. Please check any concerns you might have regarding your face or body rejuvenation:

   ❍ Wrinkles ❍ Acne ❍ Rosacea ❍ Opened Pores ❍ White/Black Heads
   ❍ Dark circles around eyes ❍ Skin Discoloration ❍ Sun Damage ❍ Broken Vessels
   ❍ Varicose Veins ❍ Excessive Hair Growth ❍ Hair Loss ❍ Tattoos ❍ Scarring
   ❍ Nail Changes ❍ Excessive Fat ❍ Stretch Marks ❍ Skin Atrophy/Thinning/Laxity
   ❍ Short Eye Lashes ❍ Thin Lips ❍ Other _____
6. Are you trying to become pregnant? ❍ Yes ❍ No

Please feel free to contact us at 856.358.1500 for a complimentary cosmetic consultation with one of our skin care specialists: Ingrid P. Warmuth MD PA, Daisy Fisher APN-C and Tina Hawk Aesthetic Director.

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Please tell us, did you hear about us...

Today's Date: _____

1. Through a patient? Please tell us who so we can thank them.

   _____

2. A referral from a family member or friend? Please let us know who.

   _____

3. A referral from your physician? Please tell us your doctor's first and last name.

   _____

4. An advertisement in the newspaper? Please circle which one:

   The Daily Journal *The Elmer Times* *Cumberland-Salem Guide* *South Jersey Times*

   The New Town Press Other _____

5. An advertisement in a magazine? Please circle which one:

   Suburban Family Magazine *Art of Living Well* *Clipper Magazine* Other _____

6. An advertisement in the phone book?

   Bridgeton/Millville Salem County Cumberland County Superpages

   Other _____

7. A placemat advertisement?

   Swedesboro Diner Harrison House Diner Woodstown Diner

8. Our Website www.drwarmuthskincarecenter.com _____

9. Our Facebook: www.facebook.com/drwarmuth _____

10. Our Twitter: www.twitter.com/dringridwarmuth _____