
NAME OF BENEFICIARY

HEALTH INSURANCE CLAIM NUMBER

I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dermatology Partners of Western New York, LLP for any services furnished me by that 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.

PATIENT/RESPONSIBLE PARTY SIGNATURE

DATE

Last Updated: 8/30/19

DERMATOLOGY PARTNERS OF WNY, LLP
HIPAA CONSENT

PATIENT NAME: _____ **DATE OF BIRTH:** _____
(LAST) (FIRST) (MI)

Primary Care Physician: _____

Additional providers to receive correspondence: _____

There are many instances where we may need to reach you to discuss information, as with appointment reminders or test results. In the event that we cannot reach you via telephone, test results may be sent by mail.

PREFERRED PHONE: (_____) _____ Cell Home

Permission to leave detailed medical message? YES NO

ALTERNATIVE PHONE: (_____) _____ Cell Home

Permission to leave detailed medical message? YES NO

By law, we may not contact individuals regarding your personal health information without your consent.

May we discuss your medical information with any others? YES NO

If **yes**, please list below:

NAME: _____ **PHONE NUMBER:** (_____) _____

RELATIONSHIP TO PATIENT: _____

NAME: _____ **PHONE NUMBER:** (_____) _____

RELATIONSHIP TO PATIENT: _____

X

PATIENT/RESPONSIBLE PARTY SIGNATURE

DATE

RELATIONSHIP TO PATIENT

Last Updated: 8/30/19

Dermatology Partners of WNY, LLP
INTAKE FORM

DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____
(LAST) (FIRST) (MI)

SEX: **M** **F** Identifies as: _____ Occupation: _____

Preferred Pharmacy and Location: _____

Past Medical History

Do you now have, or have you ever been diagnosed with the following conditions?

- | | | |
|---|---|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> COPD | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Hyperthyroid (high) |
| <input type="checkbox"/> Artificial joint (where on body?)
_____ | <input type="checkbox"/> Covid | <input type="checkbox"/> Hypothyroid (low) |
| <input type="checkbox"/> Artificial heart valve,
pacemaker, or defibrillator | <input type="checkbox"/> Depression | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Organ transplant (what organ?)
_____ |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Excessive scarring (Keloids) | <input type="checkbox"/> Radiation or chemo treatment |
| <input type="checkbox"/> Autism spectrum disorder | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer (type?) _____ | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| | <input type="checkbox"/> High blood pressure | |
| | <input type="checkbox"/> High cholesterol | |

Other medical problems not listed above: _____

List any major surgeries: _____

Skin Disease History

Have you ever had skin cancer? Yes No Not Sure

If yes, check what type(s):

Basal Cell Squamous Cell Melanoma Not Sure Other

Where on body? _____ When? _____

Do any of your blood relatives have melanoma? Yes No Relationship: _____

Do you use sunscreen? Yes No

Have you used a tanning bed? Yes No

(PLEASE SEE OPPOSITE SIDE)



DATE: _____



PATIENT NAME: _____ DATE OF BIRTH: _____
(LAST) (FIRST) (MI)

If None- List any current medications (including aspirin and over the counter medications):

If None- List any medication allergies: _____

Are you allergic to latex? Yes No

Did you get a flu shot during the most recent flu season, or do you plan to? Yes No Not sure

(Over age 50) Have you had the shingles vaccine? Yes No Not sure

(Over age 65) Have you had the pneumococcal vaccine? Yes No Not sure

Do you have any problems with your immune system? Yes No

Have you ever had a bad reaction to local anesthesia? Yes No

Do you get a rapid heartbeat with epinephrine? Yes No

Do you drink alcohol? Yes No

Do you smoke? Yes Quit No Child/not applicable

Females only

Are you pregnant or planning pregnancy? Yes No If pregnant, due date: _____

Are you breastfeeding? Yes No