Westford Dermatology & Cosmetic Center
506 Groton Rd
Westford, MA 01886

Name: ______________________________

Home Address: ____
Street City State Zip Code

Email Address: __________________________________

Date of Birth: ___________________________________

Cell Phone #: __________-___________-_____________

Home Phone #: _________- __________-_____________

Emergency Contact: ___________________/_______________/_________________________
Name Relationship Phone Number

Primary Care Physician: ____

____

Insurance Company: _______________________________

Subscriber Information: ____________________/___________________/__________________
Name Date of Birth Relationship

____

Parent or Responsible Party (if different from patient; including minors)

Name: ___________________________

Address: ____
Street City State Zip Code

Phone Number: ___________-___________-_______________

Payment is required for all services at the time they are rendered. Copayments are collected at the time of the visit. Deductibles are to be paid once medical bill summary is received via mail.
I hereby authorize and assign my insurance benefits to be paid directly to Westford Dermatology & Cosmetic Center. I authorize release of information to process insurance. I give Westford Dermatology & Cosmetic Center permission to treat and take photographs. I have received and understand Westford Dermatology & Cosmetic Center's Financial Policy and notices of Privacy Practices. Your signature below signifies your understanding and willingness to comply with these policies.

Waiver: I understand if I am required to obtain a referral from my Primary Care Doctor it is my responsibility. My insurance carrier determines when a referral is necessary. If I do not have a referral at the time of service or unable to obtain a referral for any reason I am responsible for all services rendered.
Patient or Responsible Party Signature: ________________________________ Date: _______________.

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HIPAA OMNIBUS RULE

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process insurance claims.

Date:___________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this health care facility. A copy of this document, signed and dated shall be as effective as the original.

My signature will also serve as a PHI Document Release should I request treatment or radiographs be sent to other attending doctors and facilities in the future.

_________________________________ _________________________________

Please **print** your name. Please **sign** your name.

_________________________________ _________________________________

Legal Representative Description of Authority

____

Please list any other parties who can have access to your health information:
(This includes step parents, grandparents, and any care takers who can have access to this patient records):

Name:___________________________ Relationship:_______________________

Name:___________________________ Relationship:_______________________

____

I authorize contact from this office to confirm my appointments, provide information regarding medical treatment and issues, and billing information via:

- ☐ Cell Phone Confirmation
- ☐ Text Message Confirmation
- ☐ Home Phone Confirmation
- ☐ Any of the Above

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize that this office may recommend products or services to promote or improve your health. This office may or may not receive third party remuneration from these affiliated companies. We are under current HIPPA Omnibus Rule to provide you this information with your knowledge and consent.

____

Office Use Only:
As Privacy Officer, I attempted to obtain the patient's (or representative's) signature on this acknowledgement but did not because:
It was emergency treatment:
I could not communicate with the patient:
The patient refused to sign:
The patient was unable to sign because (please describe):
Other (please describe):

____
Signature of Privacy Officer

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Medical History

NAME:____ **DOB:**___________________________

PLEASE LIST ANY **CURRENT MEDICATIONS**:

PLEASE LIST ANY **ALLERGIES** TO MEDICATIONS:

PLEASE LIST ANY **CURRENT MEDICAL CONDITIONS**:

PLEASE LIST ANY **PERSONAL** and/or **FAMILY HISTORY OF SKIN CANCER** (WHO, TYPE and BODY LOCATION):

PLEASE LIST ANY **PREVIOUS OR CURRENT SURGICAL PROCEDURES**:

PHARMACY: ____

ADDRESS	PHONE

PRIMARY CARE PHYSICIAN: ____

ADDRESS	PHONE

What is your current smoking status? **Current/Former/Never**
Have you received the Flu Vaccine for the current year? **YES or NO**
Have you received the Pneumonia Vaccine (Patients 65 years old and over)? **YES or NO**
Do you have an advanced care plan/health care proxy **YES or NO**
Proxy name and number____.