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

_____

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:* _____.**

_____

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

Name: _____

Address: _____
Street City State Zip Code

Phone Number: _____-_____-_____

continued ⟶

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** patient name — Please **sign** your name/Legal representative name

_____ _____

Please **print** legal representative name — 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:_____Phone:_____

Name:_____Relationship:_____Phone:_____

_____

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

continued ⟶

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Medical History

NAME:_____ **DOB:**_____

PLEASE LIST ANY **CURRENT MEDICAL CONDITIONS**:

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

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

PLEASE LIST ANY **CURRENT MEDICATIONS**:

PLEASE LIST ANY **ALLERGIES TO MEDICATIONS**:

PHARMACY: _____

ADDRESS	PHONE

What is your current smoking status? (Circle one). **Current/Former/Never**

Have you received the Flu Vaccine for the current year? **YES or NO**

***Patients 65 years old and over*: Have you received the Pneumonia Vaccine?** **YES or NO**

Do you have an advanced care plan/health care proxy **YES or NO**
If *YES* - Proxy name and phone number_____.