

WD Westwood Dermatology

Westwood Dermatology and Dermatologic Surgery Group, P.A.

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WELCOME

You have just made an appointment with the Westwood Dermatology Group. Please take a few minutes to complete the attached forms and return them with you at the time of your visit. This will enable our office to be more efficient and help us make every effort to remain on schedule. Our office is located at 390 Old Hook Road, Second Floor, Westwood, N.J. All our patients are seen on an appointment basis. If you are unable to keep your appointment for any reason, please give us at least 24 hours notice. This courtesy allows us to be of service to other patients. Our phone number is 201-666-9550.

If you are being referred by another Doctor, please include this information on the enclosed New Patient Information Form. We will then be able to report back to the physician promptly.

We hope you find our office and staff, pleasant, friendly, and efficient. If you have any questions regarding insurance or the attached forms, please call our office at 201-666-9550 before your visit.

Thank you in advance for your cooperation.

Appointment Date _____

Time _____

Doctor _____

Please arrive 15 minutes prior to scheduled appointment.

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OFFICE POLICY

In order to accommodate the needs and request of our patients, we have enrolled in numerous insurance programs.

While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep up to date with all of the specific and various requirements of each and every plan, **WITHOUT YOUR FULL COOPERATION**. Please understand that each plan has different stipulations such as referrals, authorizations, lab work, etc. **IT IS VERY IMPORTANT THAT YOU, THE PATIENT COME INTO OUR OFFICE WITH ALL OF THE REQUIRED DOCUMENTATION AND BE FULLY AWARE OF HOW YOUR PLAN WORKS PRIOR TO THE TIME OF YOUR SCHEDULED APPOINTMENT. YOU, THE PATIENT ARE THE POLICYHOLDER AND IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE PLAN.**

With your cooperation, we, your health care provider, can provide you with all the medical benefits to which you are entitled which is our primary concern.

*****I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED ABOVE.**

Signature

Date

NEW PATIENT INFORMATION FORM (PLEASE PRINT CLEARLY)

NAME: _____ DATE: _____

ADDRESS: _____ SEX: _____ SS#: _____

TOWN: _____ ZIP: _____ DATE OF BIRTH: _____

HOME PHONE#: _____ BUSINESS#: _____

CELL PHONE#: _____ EMPLOYER: _____

IN WHOSE NAME SHOULD THIS BE BILLED: _____

MARITAL STATUS: M __ S __ W __ D __ SPOUSE: _____

NAME OF INSURANCE CARRIER: (GIVE AS MUCH INFORMATION AS POSSIBLE)

SUBSCRIBER'S NAME: _____

SUBSCRIBER'S DATE OF BIRTH: _____

MEDICARE #: _____

SECONDARY INSURANCE (IF APPLICABLE): _____

SECONDARY #: _____

REFERRING DOCTOR: _____ ADDRESS: _____

REFERRING DOCTOR'S SPECIALTY: _____

FAMILY DOCTOR: _____ ADDRESS: _____

I HEREBY AUTHORIZE WESTWOOD DERMATOLOGY GROUP TO RELEASE TO MY INSURANCE CARRIER ANY MEDICAL INFORMATION NECESSARY FOR THE COMPLETION OF MY MEDICAL CLAIM. I UNDERSTAND THAT THIS MAY INCLUDE COPIES OF MY MEDICAL RECORDS OR LAB RESULTS.

SIGNATURE OF PATIENT
OR PARENT (IF MINOR)

DATE

**PLEASE PRESENT YOUR INSURANCE CARD TO
THE RECEPTIONIST UPON ARRIVAL!!!**

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SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our "Notice of Privacy Practices." Our full length "Notice of Privacy Practices" is available upon request.

Date of last revision: 4/11/03

Effective Date: Immediately

This information is made available on request by a patient.

THIS NOTICE DESCRIBES HOW MUCH MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail, please refer to the Notice of Privacy Practices that follows this summary):

- | | |
|--|--|
| -For medical treatment | -For research |
| -To obtain payment for our services | -For workers' compensation programs |
| -To run our practice more efficiently and ensure all our patients receive quality care | -In response to certain requests arising out of lawsuits of other disputes |
| -Required by law | -For appointment and patient recall reminder |
| -To avert a serious threat to health or safety | -In emergency situations |

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- | | |
|--|---|
| -The right to inspect and copy | -The right to request restrictions |
| -The right to amend | -The right to a paper copy of this notice |
| -The right to an accounting of disclosures | -The right to request confidential communications |

For more information about these rights, please see the detailed "Notice of Privacy Practices," which is available upon request.

I, _____, have been given the opportunity to read and/or receive Westwood
PRINT NAME
Dermatology's Notice of Privacy Practices.

Signature of Patient

Date

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Patient's Name (print) _____

I authorize Westwood Dermatology to release any laboratory or test results to, or discuss my medical condition with:

Myself _____

Spouse _____

Parent _____

Other _____

Doctor _____

Signature _____

Witness _____

Date _____

Patient name _____ Age _____ Date _____

Allergies to medicine:	Latex gloves:
Current medications:	

Reason for today's visit: (chief complaint)

Do you faint easily? ___ yes ___ no

Do you wish to have a full skin examination? ___ yes ___ no

Current or past problems with: (Review of systems)

	Yes	No	(if yes, explain)
General Health	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears/Nose/Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach/bowel	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidneys	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis/muscles/joints	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin or Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches/seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychological disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid/diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood/bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic/immunologic	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you take aspirin regularly? ___ yes ___ no

Do you take antibiotics prior to procedures (dental/surgical)? ___ yes ___ no

Females: are you pregnant? ___ yes ___ no planning to become pregnant? ___ yes ___ no

Family History: (Past family & social history)

Mother: living deceased - age _____ Father: living deceased - age _____ No. of your own children _____ age(s) _____

Check following medical conditions that have occurred in your family:

<u>Disease</u>	<u>Self</u>	<u>Mother</u>	<u>Father</u>	<u>Blood Relative</u>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malignant Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History:

Do you live alone? ___ no ___ yes

Do you drink alcohol? ___ no ___ yes-frequency _____

Occupation _____

Do you smoke? ___ no ___ yes-frequency _____

Do you use recreational drugs? ___ no ___ yes-frequency _____

Hobbies/leisure activities _____

_____ Date: _____

Reviewed _____ Date: _____

(Patient Signature)

(MD signature) Update _____