APPOINTMENT

DATE TIME

PATIENT REGISTRATION & HEALTH QUESTIONNAIRE

NAME	DATE OF BIRTH	CALL DATE
STREET ADDRESS	CITY STATE, ZIP	
PHONE # - HOME ( )	CELL # ( )	WORK # ( )
OCCUPATION EMPLOYER	SPOUSES NAME	SPOUSES BIRTHDATE
IF UNDER 18 PARENT / GUARDIAN		
EMERGENCY CONTACT (OTHER THAN SPOUSE) PHONE # ( )	ADDRESS	RELATION
S.S. #	EMAIL ADDRESS	

INSURANCE & BILLING INFORMATION

INSURANCE COMPANY	CONTRACT #, MEMBER ID		EFFECTIVE DATE
NAME INSURED	RELATION TO PATIENT	GROUP #	DED
INSURED'S BIRTHDATE			CO-PAY
INSURANCE COMPANY	CONTRACT #, MEMBER ID		EFFECTIVE DATE
NAME OF INSURED	RELATION TO PATIENT	GROUP #	DED
INSURED'S BIRTHDATE			CO-PAY

HOW DID YOU HEAR ABOUT US?

CAN WE CONTACT YOU VIA E-MAIL? __________ YES __________ NO

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical / medical benefits to **Somerset Dermatology Institute** for services rendered by him / her in person or under his / her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize **Somerset Dermatology Institute** to release any medical or incidental information. that may be necessary for either medical care or in processing applications for financial benefit.

MEDICARE * MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE

I acknowledge that I have reviewed the **Notice of Privacy Practices** and will have a copy upon request.

PATIENT NAME *(please print)* ______________________ SIGNATURE ______________________

PARENT / GUARDIAN *(please print)* ______________________ DATE ______________________

Khaled El-Hoshy, MD, PC

Somerset Dermatology Institute
Dermatology, Surgical, Cosmetic

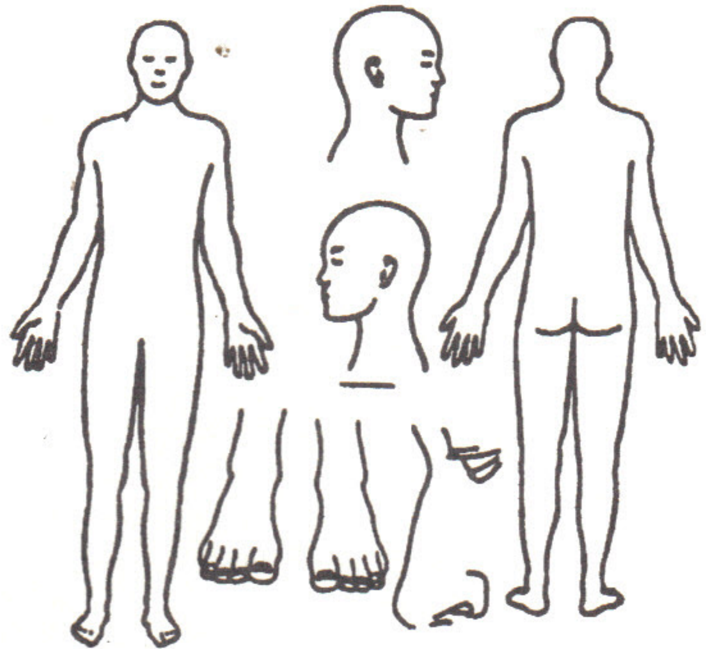
Thank You

WLFM5WH1 WZ371883C-06-12 PRINTED IN U.S.A.

HISTORY & PHYSICAL

NAME: ______________________ DATE: ______________________

DATE OF BIRTH: ______________________



FAMILY HISTORY

☐ HAY FEVER ☐ CANCER
☐ PSORIASIS ☐ ASTHMA ☐
☐ SKIN CANCER ☐ DIABETES ☐
☐ ECZEMA ☐ ARTHRITIS ☐

PAST MEDICAL HISTORY CHECK ALL THAT APPLY ☐ NONE

☐ RECENT WEIGHT LOSS / GAIN
☐ ASTHMA
☐ HIVES
☐ PSORIASIS
☐ KELOIDS
☐ SKIN CANCER
☐ AIDS RISK
☐ DIABETES
☐ CORONARY HEART DISEASE
☐ HYPERTENSION
☐ HEPATITIS
☐ KIDNEY DISEASE
☐ HAY FEVER
☐ ECZEMA
☐ HERPES
☐ THYROID
☐ MIGRAINE
☐ SEIZURES
☐ SIMPLEX
☐ LUPUS
☐ BLEEDING DIATHESE
☐ CANCER Type
☐ X-RAY THERAPY
☐ PREVIOUS SURGERY
☐ LUNG DISEASE
☐ MENST IRREG ☐ FEMALES - PREGNANT
☐ ARTHRITIS
☐ HEADACHES
☐ NEUROL. DISEASE
☐ ANEMIA

LIST ANY MEDICATION ALLERGIES

MEDICATIONS YOU ARE CURRENTLY TAKING

HABITS CIG ALCOHOL OZ. / WK.

OCCUPATION

THE REASON YOU ARE COMING IN TODAY:

- Where is your skin problem?
- When did the problem start?
- What treatment have you used for it?

REFERRED BY:

Somerset Dermatology Institute
Marian Professional Building
14555 Levan Rd., Ste 410, Livonia, MI 48154, Phone: 734-462-9499, Fax: 734-462-4124

Dear Patients:

***It is the policy at Somerset Dermatology Institute to only refill prescriptions at the following times: **MONDAY THROUGH THURSDAY FROM 9:30AM TO 3:30PM AND FRIDAY FROM 9:30 AM TO NOON.**

Please notify the office several days before you are out of the medication(s). As it may take up to 2 days to call in your request. We cannot refill prescriptions if you have not been seen in over four months. Please have your pharmacy phone number or fax number (preferably), along with the name of the prescription needed.

Prescriptions **WILL NOT** be called in on the weekends. There will be no exceptions to this policy. Thank you for your cooperation.

***** A $25 charge will be applied for missed appointments.** Please call at least 24 hrs in advance if you need to reschedule your appointment, as a courtesy to other patients on our waiting list.

*****A charge of $15 will be applied for returned checks.**

*****Office Visit Co-pays and Account Balances are due at the time the service is rendered.**

All **HMO's** must have a current referral for each and every appointment or the fees for this appointment will be the patient's responsibility **ON THE DAY OF SERVICE. IT IS THE PATIENTS RESPONSIBILITY TO GET A REFERRAL FROM HIS/HER PRIMARY CARE PHYSICIAN.**

Patients who have **MASTER MEDICAL MUST** pay all fees on the day of service. As a courtesy, our staff will file your claim to Blue Cross/Blue Shield, upon receiving payment.

Sincerely,
The Staff at Somerset Dermatology Institute

I have read and understand the policies as stated above.

______________________________ ____________________

Patient Signature — Date
Parent or Guardian if patient is a minor