

Welcome to Weimer Skin Clinic!

We are so happy that you've chosen us for your dermatological care.

Below is some important information that you need to know:

We are located at 1240 21st Ave. N., Suite 106, Myrtle Beach, SC 29577

www.weimersc.com

843-839-1414 – 843-839-1413 fax

(Option #1: Appointment; #3: Prescription refills; #4: Nurse; #6: Address)

1. **Always bring your most recent legal photo ID.**
2. **Always bring your most recent insurance cards.** If your insurance is through your spouse or parent, we will need their date of birth for insurance purposes. Even if we do not accept your particular insurance, we need the information to send with any pathology and to be able to provide you with a completed claim form.
3. We will need your social security number (we do not need to see your social security card).
4. **Always bring all your medications or an updated list** (with the date you began taking them).
5. Please fill out the attached (5) forms and arrive **15 minutes before** your scheduled appointment time (if you did not receive or if you cannot fill out the forms prior to coming in, please arrive 30 minutes before appointment time).
6. All minors must be accompanied by a parent or **legal** guardian (if legal guardian, copies of legal documents must be presented). **Please let receptionist know if you have Medical Power of Attorney (only if you are unable to make your own medical decisions) and provide copy for your chart.**
7. If you are late to an appointment, you may be asked to reschedule that appointment for another day.
8. **All Insurance co-pays, deductibles and co-insurances are due at time of service.**

\$50.00 for Missed Office Visits

(24 Hour Cancellation Notice Required for Office Visits!)

\$200.00 for Missed Surgery

(72 Hour Cancellation Notice Required for Surgery!)

In the event of an emergency, please call as soon as possible, you may leave a message.

*If you do not have a **valid** emergency, you **WILL** be billed the appropriate missed appointment charge!

We look forward to serving you!

WEIMER SKIN CLINIC, P.A.

Patient _____
Last Name First Name Initial Social Security #

Responsible Party _____
Last Name First Name Initial

Street Address _____

Mailing Address (if different from above) _____

City _____ State _____ Zip Code _____

Home Phone Number _____ Cell Phone Number _____

Birth date ____/____/____ Age _____ Sex: Male _____ Female _____

Single _____ Married _____ Widowed _____ Separated _____ Divorced _____

Employed ___ Full-Time Student ___ Part-Time Student ___ Patient's School Name _____

Patient Employed By _____

Business Address _____

Occupation _____ Business Phone _____

Spouse/Parent Name _____ Birth date _____

Spouse's Social Security Number (For Insurance Purposes) _____

Business Name & Address _____

Occupation _____ Business Phone _____

In Case of Emergency, who should be notified? _____

Phone _____ Relationship _____

Were you referred by a Doctor Yes No

If yes, please list referring Doctor _____ Office Phone# _____

Do we have permission to: Please circle

Leave a message on your answering machine at home? Yes No

Leave a message at your place of employment? Yes No

Have you enacted a Medical Power of Attorney? (Does someone have to sign for you?) Yes No

If yes, Name: _____ Phone # _____

Please provide copy of Medical POA to be kept in your chart if someone needs to sign for you.

May we discuss your medical condition with any member of your household? Yes No

If yes, whom _____ Relationship _____

Patient Signature _____ **Date** _____

*****Please present Insurance Cards and photo ID to the receptionist so copies may be made.**

Do you have Medical Insurance _____ No _____ Yes If yes: _____

Are you covered under any of these programs?

_____ Medicare; _____ BC/BS State Employee; _____ Cigna; _____ Aetna;

_____ Not covered by one of these categories

(Weimer Skin Clinic, P.A. only accepts the above insurances)

This office is required to keep a copy of your recent photo ID, Insurance cards as well as your signature on file authorizing us to file claims to Insurance companies for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare/insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature as it appears on Primary/Medicare Insurance Card

Date

I request/authorized Supplemental/Secondary benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above Supplemental/Secondary carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on Secondary, or Supplemental Card***

Date

***If you have a supplemental/Secondary policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I assign to Weimer Skin Clinic, P.A. all medical benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits authorized on all my insurance submissions whether manual or electronic.

I hereby authorize, C. Edward Weimer, Jr., MD, FAAD, to prescribe treatment, conduct necessary tests and prescribe medication as necessary.

Signature

Date

DATE _____ CHART# _____ PATIENT'S NAME _____

NEW PATIENT BRIEF MEDICAL HISTORY

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1. What is your skin problem today and when did it begin? (rash, growths, warts, acne, other): _____

PLEASE CIRCLE "YES" OR "NO" AND ANSWER THE FOLLOWING:

2. Have you had any other **past** skin problems or skin cancers? YES NO
If yes, where on your body, and when: _____

3. Do any of your blood relatives have skin problems, skin cancer, abnormal scarring YES NO
lupus, asthma/hay fever or inheritable skin diseases? (Circle and list) _____

4. Has a doctor given you anything for today's skin problem? If so, what? _____ YES NO

5. Have you put anything else on today's skin problem that you obtained yourself without YES NO
a prescription? If so, what? _____

6. Are you allergic to any medicine(s)? If so, what? _____ YES NO

7. Does anything touching your skin; such as jewelry, gloves, shoes, plants, etc; cause a rash, YES NO
itch or allergy? (Circle and list) _____

8. FOR WOMEN ONLY: Are you now pregnant, or **may** you be? YES NO

9. What else should I know about your general health: such as past surgery, easy bleeding, Asthma,
diabetes, lupus, high blood pressure, heart disease, hepatitis, organ recipient, HIV/AIDS, or need or
receiving antibiotics prior to dental work or invasive surgery? (Circle and list) _____

10. List all your **current medications** prescriptions and any over the counter medications and supplements:

Who is your primary care physician? _____ Phone # _____

Patient's, Parent or Legal Guardian's (circle one) **Signature** _____

Dermatologist's **Signature** (signifying review) _____

C.Edward Weimer, Jr., MD, FAAD

**Weimer Skin Clinic, P.A. accepts
Medicare Part B –
BCBS State Employees –
Aetna - Cigna**

**INSURANCE CO-PAYS, DEDUCTIBLES AND CO-INSURANCES ARE DUE AT
TIME OF SERVICE**

Patients with Medicare Part B as their primary insurance will be required to pay up to 20% depending on your secondary insurance plan, until a history is established.

If you do not carry an insurance that we accept– **Payment is required at the time of service** – we accept Cash, Check, Visa, and Mastercard and Discover.

The following fees will be incurred for missed (no show) appointments and appointments that are not cancelled with the courtesy of a 24 – 72 hour notice. (Please understand that the 24 - 72 hour notice will give us the opportunity to offer your office visit or surgery time to someone else who may be waiting to be seen).

Thank you for your understanding.

\$50.00 for Missed Office Visits

(24 Hour Cancellation Notice Required for Office Visits!)

\$200.00 for Missed Surgery

(72 Hour Cancellation Notice Required for Surgery!)

In the event of an emergency, please call as soon as possible.

*If you do not have a valid emergency, you WILL be billed the appropriate missed appointment charge!

I certify that I have read and understand the statements above:

Signature (Patient's/Guardian's/Parent's)

Date

Printed Name (Patient's/Guardian's/Parent's)

DATE _____ CHART# _____ PATIENT'S NAME _____

REVIEW OF SYSTEMS TODAY
(To Be Completed by the Patient/Parent/POA)

Please answer by checking or circling the box beside the body system that **is feeling abnormal or not well today; i.e., you are having these symptoms today.**

Constitutional Symptoms

- Don't Feel Good/Don't Know Why
- Fever, Chills
- Loss of Appetite
- Unplanned Weight change
- Weakness, Fatigue

Eye Symptoms

- Blurry or Double Vision
- Itchy or Red Eyes or Eyelids
- Glasses or Contacts

Ear,Nose,Mouth,Throat Symptoms

- Dental Work Needs Done
- Itching or Discomfort
- Nose or Mouth Bleeding or Sores
- Chewing or Swallowing Difficulty
- Taste or Smell Disturbance
- Hearing Loss or Ringing Sounds

Cardiovascular Symptoms

- I have an artificial heart valve
- I must take antibiotics before dental work
- I Take Blood Thinners
- I Have a Pacemaker
- Past Blood Clots
- Chronic Leg Swelling
- Shortness of Breath

- Chest Pain w or w/o Exertion
- High Blood Pressure
- Palpitations (Rapid Thumping)
- Fainting Spells

Respiratory Symptoms

- Cough / w Phlegm or Blood
- Hay Fever / Sneezing
- Asthma / Wheezing

Gastrointestinal Symptoms

- Past Hepatitis A, B, or C
- High Liver Tests
- Frequent Heartburn
- Nausea / Vomiting
- Diarrhea
- Bloody Bowel Movement
- Any Type of Chronic Colitis

Musculoskeletal Symptoms

- I Have an Artificial Joint(s)
- I Have a Prosthetic Limb
- Joint Swelling / Pain / Stiffness
- Unexplained Muscle Aches
- Difficulty Walking or Standing

Genitourinary Symptom

- Kidney Disease or Kidney Failure

- Genital Warts or STDs

- Burning on Urination
- Recurrent Sores on Genitals

Skin &/or Breast Symptoms

- New or Changing Mole or Growth
- Nonhealing Sore or Wound
- MRSA or Other Skin Infection
- Itchy Skin
- Red or Scaly / Flakey Skin
- Sunburn Easily or Photosensitivity

- Unexplained Skin or Mouth Blisters
- "Crawling" Skin Sensation
- "Burning" Skin Sensation

Neurological Symptoms

- Headaches / Migraines
- Dizziness / Balance Problems
- Numb Areas of Skin
- Seizure Disorder
- Partial Paralysis

Psychiatric Symptoms

- Depression
- Poor or Impaired Memory
- High Anxiety / Worry
- Excessive Alcohol Consumption
- Addictive Behaviors

Endocrine Symptoms

- High Blood Sugar / Diabetes
- High Cholesterol or High Lipids
- Thyroid Problem or Goiter

Hematologic/Lymphatic Symptoms

- HIV positive
- Abnormal Blood Count or Anemia
- Unexplained or Easy Bruising
- Swollen "Glands"
- Have Been Told You're Immunosuppressed

Allergic/Immunologic Symptoms

- Drug Allergies
- Hives
- I Take "Allergy Shots"

Patient's/Parent's/POA's Signature _____

Dermatologist's Signature (Signifying Review) _____

C. Edward Weimer, Jr., MD, FAAD