

Name of Patient: _____ Date of Birth: _____
(Last, First, Middle) (Month, Day, Year)

Sex: Male Female Social Security Number: _____ - _____ - _____

Marital Status: M W S D If married spouse's name: _____

If patient is a minor please provide the names of parents/guardians: _____

Local Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Alternate Number: _____

Alternate Address: _____

City: _____ State: _____ Zip: _____

Primary Physician: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Occupation of Patient or Parent Guardian: _____

Employer: _____ Phone: _____

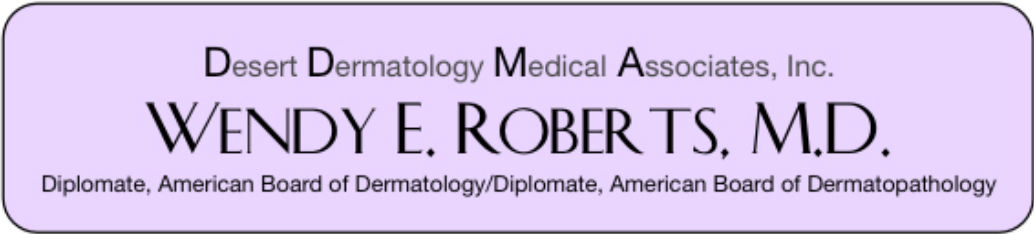
Employer's Address: _____

Are you retired? Yes No If retired, from what profession? _____

Spouse's Occupation: _____

Spouse's Employer: _____ Phone: _____

Is your spouse retired? Yes No If retired, from what profession? _____



In case of emergency, please contact: _____

Relationship: _____

Phone: _____

Any alternate #'s where Emergency Contact may be reached: _____

How did you learn about Dr. Roberts? _____

If directly referred by another Physician, what Physician? _____

Primary Insurance Carrier: _____

Policy#: _____

Secondary Insurance Carrier: _____

Policy# _____

In order to establish optimal relations with our patients, and to avoid misunderstanding and confusion regarding our payment policies, our Staff is trained to consistently inform you of the financial payment policies of this office.

Our office submits claims only to Medicare. All other insurances, including secondary insurances, are considered private. Payment of any un-met deductible, co-payments, or non-covered/cosmetic procedures will be collected at the time of service. Claims submission to private or secondary insurances is the responsibility of the patient. If you are on a secondary insurance plan, which does not automatically coordinate benefits with Medicare, you are responsible for either submitting the information necessary for your secondary insurance to pay their portion directly to Dr. Roberts, or for paying the balance and then submitting to your secondary for your reimbursement.

Payment in full is required for all services at the time they are rendered. We accept payments in the form of: Cash, Check, MasterCard, Visa or Discover.

Assignment: I hereby assign my benefits directly to Wendy E. Roberts, M.D.

Release: I authorize Wendy E. Roberts, M.D. to release to my Insurance Carrier(s) any information required to process claim(s) from services rendered to me.

My signature below signifies my understanding and willingness to comply with these policies.

Acknowledged: _____ Date: _____

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Sex : Female Male Marital Status: M W S D

Please list any food allergies:

Please list any current medications you are taking:

Please list any recent surgical procedures:

Do you have now, or have you ever had any of the following conditions:

Lungs	Yes	No	Other Systematic	Yes	No
Bronchitis	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>
Emphysema	<input type="radio"/>	<input type="radio"/>	Thyroid	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	Kidney	<input type="radio"/>	<input type="radio"/>
Chronic Cough	<input type="radio"/>	<input type="radio"/>	Bladder	<input type="radio"/>	<input type="radio"/>
Morning Cough	<input type="radio"/>	<input type="radio"/>	Stomach	<input type="radio"/>	<input type="radio"/>
			Bowel	<input type="radio"/>	<input type="radio"/>
Vascular	Yes	No	Hepatitis or Yellow Skin	<input type="radio"/>	<input type="radio"/>
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	Glaucoma	<input type="radio"/>	<input type="radio"/>
Chest Pain	<input type="radio"/>	<input type="radio"/>	Arthritis/Joint Deformity	<input type="radio"/>	<input type="radio"/>
Heart Attack	<input type="radio"/>	<input type="radio"/>	Convulsions, Epilepsy, or Seizures	<input type="radio"/>	<input type="radio"/>
Heart Murmur	<input type="radio"/>	<input type="radio"/>	Fainting	<input type="radio"/>	<input type="radio"/>
Irregular Heartbeat	<input type="radio"/>	<input type="radio"/>			
Pacemaker	<input type="radio"/>	<input type="radio"/>			
Phlebitis	<input type="radio"/>	<input type="radio"/>			

Do you drink alcohol? Yes No If yes, number of drinks per week _____

Do you use IV drugs? Yes No If yes, what _____ How often? _____

Do you smoke? Yes No If yes how often? _____

Do you bleed easily? Yes No (Women) Are you pregnant? Yes No if yes, due date: _____

Desert Dermatology Medical Associates, Inc.
WENDY E. ROBERTS, M.D.
Diplomate, American Board of Dermatology/Diplomate, American Board of Dermatopathology

Have you been exposed to HIV / AIDS Yes No If the answer is yes, are you HIV positive? Yes No

Have you ever had dental anesthesia (Novocain)? Yes No Any bad reaction? Yes No

When exposed to the sun, do you: Tan Burn Tan and Burn

Have you ever had skin cancer? Yes No If yes, What kind: _____

Has anyone in your family had skin cancer Yes No If yes, what kind: _____

Do you have a history of any specific skin diseases? Yes No

If yes, Please list: _____

List any other disease or conditions we should know about: _____

Dear Patient,

New technologies have expanded the usage of products and procedures available to enhance the appearance of your skin. To help us provide you with the services you desire and optimal treatment, we request that you let us know about your skin care needs by checking them below. It would also provide insight to our newfound relationship if you would check the skin care services which you are interested in obtaining more information about or wish to have done in the future. Please take a few moments and provide us with this very important information.

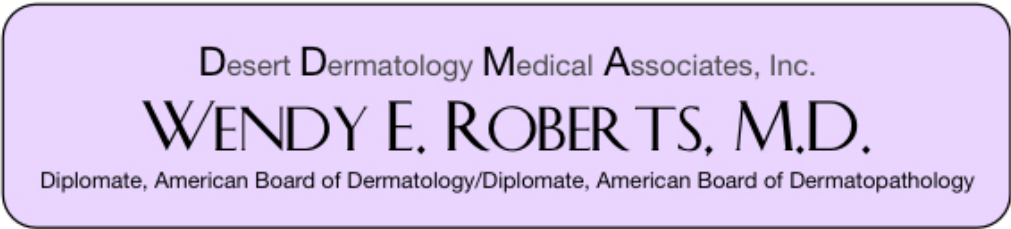
Thank You!

YOUR SKIN CARE NEEDS

- Acne
- Aging Skin
- Dry, Itching Skin
- Facial Lines & Wrinkles
- General Skin Care (cleansing, moisturizing, etc.)
- Photo-damage (sun damage)
- Hair Growth
- Hair Loss
- Skin Cancer
- Spider veins (facial or legs)
- Other : _____

RECOMMENDED SKIN CARE SERVICES

- Acne Treatment, Acne Laser, Cool Touch Laser
- Cosmetic Consultation, Botox Injection, Fillers, Laser, Skin Rejuvenation
- Body Peeling, Dr. Wendy Skin and Body Boutique
- Chemical Peels, Juvederm, Radiesse, Sculptra, and Restylane
- General Skin Care Advice, Product Regimens, and Dr. Wendy Skin and Body Boutique
- Laser Resurfacing, ELOS, Aurora
- Hair Laser Removal
- Diagnosis & Management
- Full Body Skin Examination, Digital Mole Mapping, MOHS Surgery
- Sclerotherapy, Vein Laser
- Other: _____



Lifetime Beneficiary Claim Authorization and Information Release

Patient's Name

Medicare ID Number

I hereby assign/request that payment of authorized Medicare benefits be made directly to Wendy E. Roberts, M.D for services rendered to me by her.

I understand that because Dr. Roberts accepts Medicare assignment, she agrees to accept the Medicare allowed amount as payment in full. I understand that once Medicare has paid their portion, a coinsurance balance of 20% of their allowed amount remains. I understand that claims will be submitted to my Secondary Insurance by Dr. Roberts for this balance. If my Secondary Insurance does not automatically coordinate benefits with Medicare, I accept responsibility for claim submission to them for subsequent payment of the 20% coinsurance balance. If I elect not to submit my claim to my Secondary Insurance for payment of the 20% coinsurance, I accept responsibility for the payment of this balance in full. I understand that I am responsible for the Part B deductible (if not paid by my Secondary Insurance) and all non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

I understand that if Dr. Roberts has received no payment from Medicare ninety (90) days after billing Medicare, I am fully and personally responsible for paying the charges to Dr. Roberts.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to process the claim.

Patient's Signature

Date