Confidential Patient Information B1 C1 D1 E1 **Please print & complete all questions both sides**

1._____ , Mr. Mrs. Ms. Dr. 2._____
patient's last name **patient's first name** m.i.

3. Address: _____ 4. Box/Apt #: _____

5. City _____ State_____ Zip _____ Occupation: _____

6.Home phone:_ _ _ - _ _ _ - _ _ _ _ Work phone: _ _ _ - _ _ _ - _ _ _ _ Cell phone: _ _ _ - _ _ _ - _ _ _ _

7. Soc. Security #: _ _ _ - _ _ - _ _ _ _ 8. Gender M F 9. Marital Status: S M W D Separated

10. Email _____ Birthdate _____/_____/_____ Appt. Date: _____/_____/_____
month/day/year month/day/year

Do we have your permission to discuss your medical condition with other members of your household? **Yes No**

If yes, please list their name and relationship to you. _____
Name & phone number of nearest relative or friend **not** living with you whom we may contact if needed.

first name_____ last name_____ Phone (_ _ _) - _ _ _ - _ _ _ _

Were you referred to Dr. Marley by a Doctor? (name and phone #)

Who is your personal family physician_____ address: _____ phone#

Person responsible for billing purposes Mr Mrs Ms _____, _____
if different than above or if pt is less than 18 yrs old last name first name

Their address:_____ Their relationship to patient: _____

Their City_____ State_____ Zip _____

Their Home phone #: _ _ _ - _ _ _ - _ _ _ _ Work#: _ _ _ - _ _ _ - _ _ _ _ Cell #: _ _ _ - _ _ _ - _ _ _ _

Their birthdate (m/d/yr) _____/_____/_____ Their Soc. Security #: _ _ _ - _ _ - _ _ _ _

Your Medical Insurance Information

1.Primary Carrier:_____ Secondary (co) Carrier: _____

Insured name: _____ Insured name: _____

Insurance ID# _____ Insurance ID# _____

Group #_____ Group # _____

Subscriber's birth date m___ /d___ /yr_____ SS# ____ -____ -_____ gender: M F

Please complete other side

Page:_____ Pt. Name:_____ Visit Date: _____

Are you covered by a prescription plan? Yes [ ] No [ ]
Are you allergic to any medication? Yes [ ] No [ ] If yes, please list _____

Are you allergic to any anesthetics? Yes [ ] No [ ] If yes, please list _____

Do you take medicines regularly? Yes [ ] No [ ] If yes, please list prescription & over-the-counter
Aspirin?
Plavix?
Coumadin?

SINCE YOUR LAST VISIT HERE HAVE YOU HAD: (please answer each question and circle response)

Hepatitis	yes	no	Transfusions	yes	no	Diabetes	yes	no	Lupus	yes	no
Aids/ARC	yes	no	Easy Bruising	yes	no	High Blood Pressure	yes	no	Stroke	yes	no
Tuberculosis	yes	no	Migraines	yes	no	Bypass Surgery	yes	no			
Cancer	yes	no	Peptic Ulcers	yes	no	Heart Attack	yes	no			
Asthma	yes	no	Glaucoma	yes	no	Pacemaker	yes	no			
			Joint Replacement?			Organ Transplant?			Other Problems?		

ROS

1.Constitutional: Do you have fever or chills? yes no
Do you feel well in general? yes no
2. Eyes: Do you wear glasses, contacts, or a prosthesis? yes no
3. E,N,T : Do you wear a hearing aid or dentures? yes no
4. Cardiovasc: Do you have a murmur or artificial valve? yes no
5. Resp: Do you have a cough or trouble breathing ? yes no
6. Gastrointestinal: Do you get diarrhea from antibiotics? yes no
7. Musculoskeletal: Do you have arthritis or artificial joint? yes no
8. Integumentary : Do you have other skin problems? yes no
9. Neurological: Have you ever had a stroke? yes no
10.Psychiatric: Does this problem cause stress for you ? yes no
11.Endocrine: Have you ever had a hormone problem? yes no
12.Hematologic: Do you have a bleeding problem? yes no
13.Immunologic: Is your immune system OK? yes no
14.Are you required to take antibiotics before certain surgical procedures? yes no
If so, which antibiotic? at what dosing?

Since your last visit

Have you had radiation treatments? **YES NO** If **YES**, where on your body ? when?
Have you done purposeful "sunbathing"? **YES NO** How many sunburns have you had since your last visit?
Have you had a blistering sunburn? **YES NO** If **YES**, how many? When was the last one?
Have you used tanning beds? **YES NO** If **YES**, how many times per week? When was the last time?
Have you had skin cancer? **YES NO** If **YES**, when what type?
where on your body ? how was it treated?
Do or did you work outdoors? **YES NO** Do you wear sunscreens? **YES NO**
Do you have outdoor hobbies? **YES NO** If **YES** please list your hobbies _____

Have you or anyone in your family been diagnosed with **melanoma** skin cancer? **YES NO**
If **YES**, was it you or your mother father sister brother child ?

Please describe any other medical problems or surgery you have or have had.

PLEASE TELL US WHAT SPECIFIC PROBLEM YOU ARE COMING TO SEE DR. MARLEY FOR

PAYMENT POLICY

INSURANCE COVERAGE: We participate with many carriers. We will be pleased to help you obtain the appropriate benefit from your insurance carrier and bill your insurance company as a courtesy to you. However, you are ultimately responsible for payment of your account. We will be happy to request a pre estimate of benefits from your insurance carrier if you ask us to do so. Routine treatment is generally performed without submitting a pre estimate of benefits. Portions of your bill may not be paid by the insurance company and are to be paid by you. Sometimes there is a co-payment required by you as per your insurance agreement. Even if you have double coverage (this is possible if you and your spouse both have different insurance carriers), there may still be a portion that will be your responsibility. Please be aware that we cannot guarantee your carrier's payment.

MEDICAL RECORDS: We are happy to forward copies of chart records provided we have an original signed release from the patient or the patient's legal guardian directing us to do so. Photocopies or faxes are not acceptable. For confidentiality reasons all requests must be mailed. There is a charge of $10 to cover postage and expenses incurred for retrieval and copying of records. For charts more than 10 pages, there is an additional charge of $1 per page. In case of a medical emergency, Dr. Marley will be happy to speak by phone to the treating physician.

RETURNED CHECKS / COLLECTION: Checks returned by your bank are subject to a $25 processing charge. If your account is referred to an outside agency for collection you will be responsible for the collection costs (the greater of one third of your account or $50), together with any reasonable attorney's fees and court costs.

MISSED APPOINTMENTS: We try our best to accommodate all our patients and call to confirm appointments 2 working days in advance. We understand that everyone has busy schedules that sometimes require last minute changes in your appointment which results in your being a "no-show" for that appointment. A new patient with 2 consecutive such no shows will be charged $40 and required to send payment and a deposit to reschedule a third new patient appointment. An established patient (i.e., has been seen within 3 years) will have the first no-show waived. A second consecutive no-show will be charged as above. A patient with 3 no shows within 3 years will be charged for the third no show. Canceling an appointment on the day of the appointment is considered a no show. Your courtesy is appreciated.

I have read, understand and agree to the above.

X_____ _____

SIGNATURE OF PATIENT OR GUARDIAN TODAY'S DATE

AUTHORIZATION FOR ASSIGNMENT OF INSURANCE BENEFITS

and request to leave messages on **1. your answering machine** **yes** **no**

2. voice message on cell phone **yes** **no**

Patient's Name _____

(please print)

I request that payment of any and all authorized medical insurance benefits be made on my behalf to Wayne Marley, M.D., 1950 Street Road, Suite 100, Bensalem, PA 19020 for any covered services furnished me by that physician. I authorize any holder of medical information about me to release to my insurance company or its agents any information needed to determine these benefits payable for related services. I understand that I am responsible for any deductible, coinsurance, and non covered services.

Signature of Patient / Guardian X _____ Date _____