

JAY D. GELLER, M.D., P.C.

ADULT PEDIATRIC DERMATOLOGY

Welcome To Our Office

Today's Date: _____

PERSONAL INFORMATION (PLEASE PRINT)

Patient's Name (Last)		First	Middle	Home Phone	Cell Phone		
Patient's Address			City	State	Zip		
Sex M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Other					

Email Address:

Responsible Party's Name (Last)		First Name	Relationship to Patient	Home phone	Work Phone	
Responsible Party's Address (If different)			City	State	Zip	

EMPLOYER INFORMATION

Name of Employer	Occupation	Work Phone
Name of Spouse's Employer	Occupation	Work Phone

How did you hear about us? Internet Family member Friend Referring physician
 Other specify _____ Insurance Phone book

Name, Address, and Phone of Contact in Case of Emergency _____
Relationship _____

INSURANCE INFORMATION

#1 Primary Insurance Co. Name		#2 Secondary Insurance Co Name	
Policy Holder's Name	Date of Birth	Policy Holder's Name	Date of Birth
Relationship		Relationship	
ID #		ID #	
Plan or Group #		Plan or Group #	
Policy Holder's Employer		Policy Holder's Employer	

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

RELEASE OF INFORMATION: I authorize the release of any medical information to process my insurance claim.

Signature of Patient

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to Jay D. Geller, M.D., P.C. for any services provided.

Signature

I UNDERSTAND THAT I AM EXPECTED TO PAY FOR ALL SERVICES AT THE TIME THEY ARE RENDERED. IF, AT ANY TIME, MY ACCOUNT SHOULD BECOME DELINQUENT, I AUTHORIZE THE PHYSICIAN TO BILL ME FOR THE OUTSTANDING BALANCE. I FURTHER UNDERSTAND THAT IF, AT ANY TIME, MY ACCOUNT SHOULD BECOME UNCOLLECTIBLE, I AM RESPONSIBLE FOR PAYMENT OF ANY FEES INCURRED IN THE COLLECTION PROCESS. Date: _____

Signature: _____

PATIENT QUESTIONNAIRE

Date: _____ Jay D. Geller, MD, PC

Patient's Name _____

INSTRUCTIONS: CHECK THE BOXES THAT ARE APPLICABLE TO YOU. IF LINES ARE PROVIDED, PLEASE WRITE IN YOUR ANSWER. IF INAPPLICABLE, PLEASE ACKNOWLEDGE WITH AN N/A.

	FAMILY HISTORY																					
	FATHER	MOTHER	BROTHER				SISTER				SPOUSE	CHILDREN										
			1	2	3	4	1	2	3	4		1	2	3	4	5	6					
<input type="checkbox"/> MALIGNANT MELANOMA																						
<input type="checkbox"/> SKIN CANCER (NON-MELANOMA)																						
<input type="checkbox"/> ATYPICAL MOLES																						
<input type="checkbox"/> ACNE																						
<input type="checkbox"/> ASTHMA, ECZEMA, ALLERGIES																						
<input type="checkbox"/> PSORIASIS																						
<input type="checkbox"/> OTHER (SPECIFY)																						

PAST MEDICAL HISTORY		
<input type="checkbox"/> PNEUMONIA	<input type="checkbox"/> DIABETES	<input type="checkbox"/> SURGERY (LIST):
<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> HYPERTENSION	_____
<input type="checkbox"/> HEPATITIS <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> CANCER (SPECIFY)	_____
<input type="checkbox"/> ARTHRITIS	_____	<input type="checkbox"/> ANY OTHER DISEASES:
<input type="checkbox"/> BONE DISEASE	<input type="checkbox"/> HIV INFECTION	_____
<input type="checkbox"/> GONORRHEA	<input type="checkbox"/> EPILEPSY	_____
<input type="checkbox"/> SYPHILIS	<input type="checkbox"/> HAY FEVER	HEIGHT: FEET _____ INCHES _____
<input type="checkbox"/> ANEMIA	<input type="checkbox"/> ASTHMA	WEIGHT: NOW _____ ONE YEAR AGO _____
<input type="checkbox"/> JAUNDICE	DO YOU HAVE FREQUENT: <input type="checkbox"/> COLDS <input type="checkbox"/> SORE THROAT <input type="checkbox"/> INFECTIONS <input type="checkbox"/> BOILS	

ALLERGIES		
<input type="checkbox"/> PENICILLIN	<input type="checkbox"/> ASPIRIN	<input type="checkbox"/> OTHER DRUGS OR FOOD: _____
<input type="checkbox"/> SULFA	<input type="checkbox"/> CODEINE	<input type="checkbox"/> HAIRSPRAY <input type="checkbox"/> PERFUME <input type="checkbox"/> NAIL POLISH
<input type="checkbox"/> DILANTIN	<input type="checkbox"/> PHENOBARBITAL	<input type="checkbox"/> OTHER COSMETICS _____
		<input type="checkbox"/> EARRINGS <input type="checkbox"/> RINGS <input type="checkbox"/> WATCHES <input type="checkbox"/> BRACELETS

DERMATOLOGIC HISTORY			
<input type="checkbox"/> PSORIASIS	<input type="checkbox"/> DYSPLASTIC OR ATYPICAL MOLES	<input type="checkbox"/> LICHEN PLANUS	<input type="checkbox"/> VASCULITIS
<input type="checkbox"/> TINEA VERSICOLOR	<input type="checkbox"/> HERPES SIMPLEX	<input type="checkbox"/> LUPUS ERYTHEMATOSUS	<input type="checkbox"/> PEMPHIGUS
<input type="checkbox"/> MYCOSIS FUNGOIDES	<input type="checkbox"/> HERPES ZOSTER (SHINGLES)	<input type="checkbox"/> ALOPECIA AREATA	<input type="checkbox"/> BULLOUS PEMPFIGOID
<input type="checkbox"/> CUTANEOUS LYMPHOMA	<input type="checkbox"/> URTICARIA (HIVES)	<input type="checkbox"/> GENITAL WARTS	<input type="checkbox"/> DERMATOMYOSITIS
<input type="checkbox"/> BASAL CELL CARCINOMA	<input type="checkbox"/> VITILIGO	<input type="checkbox"/> MOLLUSCUM CONTAGIOSUM	<input type="checkbox"/> DERMATITIS HERPETIFORMIS
<input type="checkbox"/> SQUAMOUS CELL CARCINOMA	<input type="checkbox"/> HAND DERMATITIS	<input type="checkbox"/> PHOTOSENSITIVITY	<input type="checkbox"/> PYODERMA GANGRENOSUM
<input type="checkbox"/> MALIGNANT MELANOMA	<input type="checkbox"/> PITYRIASIS ROSEA	<input type="checkbox"/> KAPOSII'S SARCOMA	<input type="checkbox"/> HIDRADENTIS
<input type="checkbox"/> BOWEN'S DISEASE	<input type="checkbox"/> PITYRIASIS LICHENOIDES	<input type="checkbox"/> PITYRIASIS RUBRA PILARIS	<input type="checkbox"/> LS&A
<input type="checkbox"/> OTHER SKIN CANCERS	<input type="checkbox"/> ATOPIC DERMATITIS (ECZEMA)	<input type="checkbox"/> MORPHEA OR SCLERODERMA	<input type="checkbox"/> OTHER _____

REVIEW OF SYSTEMS	
DO YOU HAVE OR HAVE YOU EVER HAD PROBLEMS WITH THE FOLLOWING:	
<input type="checkbox"/> CONSTITUTIONAL SYMPTOMS (FEVER, WEIGHT LOSS, WEIGHT GAIN, CHRONIC FATIGUE, ETC.) _____	<input type="checkbox"/> EYES _____
<input type="checkbox"/> EYES _____	<input type="checkbox"/> EARS, NOSE, MOUTH, THROAT _____
<input type="checkbox"/> CARDIOVASCULAR (PALPITATIONS, ANGINA, ETC.) _____	
<input type="checkbox"/> RESPIRATORY (SHORTNESS OF BREATH, SPITTING UP BLOOD, ETC.) _____	
<input type="checkbox"/> GASTROINTESTINAL (STOMACH ULCERS, GALL BLADDER, COLITIS, HEMORRHOIDS, ETC.) _____	
<input type="checkbox"/> GENITOURINARY (KIDNEY STONES, ETC.) _____	
<input type="checkbox"/> MUSCULOSKELETAL _____	<input type="checkbox"/> NEUROLOGICAL _____
<input type="checkbox"/> INTEGRUMENTARY (SKIN AND/OR BREAST) _____	<input type="checkbox"/> PSYCHIATRIC _____
<input type="checkbox"/> ENDOCRINE (ENLARGED GLANDS, THYROID, ETC.) _____	
<input type="checkbox"/> HEMATOLOGIC/ LYMPHATIC _____	<input type="checkbox"/> ALLERGIC/ IMMUNOLOGIC _____

SOCIAL HISTORY	
HOW OFTEN DO YOU USE:	<input type="checkbox"/> SEDATIVES <input type="checkbox"/> NEVER <input type="checkbox"/> OCC. <input type="checkbox"/> FREQ. <input type="checkbox"/> DAILY
<input type="checkbox"/> LAXATIVES <input type="checkbox"/> NEVER <input type="checkbox"/> OCC. <input type="checkbox"/> FREQ. <input type="checkbox"/> DAILY	<input type="checkbox"/> ALCOHOLIC BEVERAGES: _____ DRINKS PER WEEK
<input type="checkbox"/> VITAMINS <input type="checkbox"/> NEVER <input type="checkbox"/> OCC. <input type="checkbox"/> FREQ. <input type="checkbox"/> DAILY	<input type="checkbox"/> COFFEE: _____ CUPS PER DAY
<input type="checkbox"/> DIET PILLS <input type="checkbox"/> NEVER <input type="checkbox"/> OCC. <input type="checkbox"/> FREQ. <input type="checkbox"/> DAILY	<input type="checkbox"/> CIGARETTES: _____ PACKS PER DAY
<input type="checkbox"/> CIGARS <input type="checkbox"/> NEVER <input type="checkbox"/> OCC. <input type="checkbox"/> FREQ. <input type="checkbox"/> DAILY	<input type="checkbox"/> PIPE <input type="checkbox"/> NEVER <input type="checkbox"/> OCC. <input type="checkbox"/> FREQ. <input type="checkbox"/> DAILY
<input type="checkbox"/> CHEWING TOBACCO <input type="checkbox"/> NEVER <input type="checkbox"/> OCC. <input type="checkbox"/> FREQ. <input type="checkbox"/> DAILY	<input type="checkbox"/> NARCOTICS <input type="checkbox"/> NEVER <input type="checkbox"/> OCC. <input type="checkbox"/> FREQ. <input type="checkbox"/> DAILY

MEDICATIONS
PLEASE LIST ALL OF THE MEDICATIONS YOU ARE CURRENTLY TAKING. _____

REVIEWED BY: _____

DATE: _____