DERMATOLOGY AND COSMETIC MEDICINE SPECIALISTS

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Date: ____________________

PATIENT INFORMATION			
Patient's Name (Last):	First:	Middle:	
Patient's Address:	City:	State:	Zip:
Please check the best number to contact you:	Home ☐	Cell ☐	Work ☐

Sex: M ☐ F ☐ | Date of Birth: | Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other ☐

Email Address: | Additional Email Address: ☐ | SSN# ____________

Reminder Calls: *(How would you like to receive?)* Check All that apply Home Phone ☐ Cell Phone ☐ Text Message ☐ Email ☐

Consent to receive automated reminder calls on cell phone (if checked above):______________________(please initial here)

Language:
English ☐ Other ☐ (Specify)_____________

Race: White ☐ Asian ☐
Black or African American ☐ Other ☐

Ethnicity: Hispanic or Latino ☐
NOT Hispanic or Latino ☐

Whom may we thank for referring you?

☐ Family Member

Name: ____

Name: ____

Name: ____

☐ Friends

Name: ____

Name: ____

Name: ____

Name: ____

☐ Primary Care Physician Name + Location: ______________________________

☐ Insurance/Insurance Website

☐ Google/other internet search

☐ ZocDoc

☐ Other please specify: ______________________________

GUARANTOR/RESPONSIBLE PARTY: **(IF DIFFERENT FROM ABOVE)**	**DERMATOLOGY PATIENTS ONLY (NON COSMETIC)**			
Guarantor's Name (Last)	First	Middle	Home Phone	Cell Phone
Guarantor's Address:	City:		State:	Zip:

EMERGENCY CONTACT:	**ALL PATIENTS PLEASE COMPLETE**	
Name:	Phone:	Relationship:

INSURANCE INFORMATION: DERMATOLOGY PATIENTS ONLY (NON COSMETIC)

PRIMARY INSURANCE: Please complete and present insurance card to receptionist)

Primary Insurance Company Name:		Policy Holder Name:	Policy Holder Date of Birth:	
Policy Number:	Group Number:	Relationship: Self ☐ Spouse ☐ Parent ☐ Other ☐	Specialist Co-pay:	Policy Holder Employer:

SECONDARY INSURANCE: Please complete and present insurance card to receptionist)

Secondary Insurance Company Name:		Policy Holder Name:	Policy Holder Date of Birth:	
Policy Number:	Group Number:	Relationship: Self ☐ Spouse ☐ Parent ☐ Other ☐	Specialist Co-pay:	Policy Holder Employer:

DATE:__________________

HISTORY AND INTAKE FORM

NAME:____________________ __________________________ **DOB:**______/______/______

(First) **(Last)**

PHARMACY:_______________________ **LOCATION:** __________________ **PHONE:** (_____) ________________

(Please circle all that apply)

PAST MEDICAL HISTORY

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Asthma	End Stage Renal Disease	Lymphoma
Atrial Fibrillation	GERD	Prostate Cancer
Bone Marrow	Hearing Loss	Radiation Treatment
BPH	Hepatitis	Seizures
Breast Cancer	High Blood Pressure	Stroke
Colon Cancer	HIV/AIDS	OTHER:_________________________
COPD	High Cholesterol	_________________________________
Coronary Artery Disease	Thyroid (Hyper/Hypo)	**NONE**

(Please circle all that apply)

PAST SURGICAL HISTORY:

Appendix Removed	Heart Transplant	Prostate Biopsy
Bladder Removed	PTCA	Prostate Removed/Prostate Cancer
Breast Biopsy(Right/ Left)	Joint Replacement	TURP (Prostate Removal)
Lumpectomy(Right/ Left)	Hip (Right/Left)	Skin Biopsy
Mastectomy (Right/Left)	Knee (Right/Left)	Excision of Basal Cell Carcinoma
Colectomy:	Kidney Biopsy (Nephrectomy)	Excision of Squamous Cell Carcinoma
Colon Cancer Resection	Kidney Removed (Right, Left)	Excision of Melanoma
Diverticulitis	Kidney Stone Removal	Spleen Removal
IBD	Kidney Transplant	Testicles Removed (Right/Left)
Gallbladder Removed	Liver Transplant	Hysterectomy: Fibroids
Coronary Artery Bypass	Ovaries Removed: Endometriosis	Hysterectomy: Uterine Cancer
Biological Valve Replacement	Ovaries Removed: Ovarian Cancer	OTHER:_________________________
Mechanical Valve Replacement	Ovaries Removed: Cyst	**NONE**

(Please circle all that apply)

SKIN DISEASE HISTORY

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	OTHER:_________________________

Do you have a **FAMILY** history of **Melanoma**? If yes, which relatives:___________

YES NO _________________________________

NAME:____

MEDICATIONS: All current medications, vitamins, supplements (Please provide separate attachment if more than 6 medications.)		
Name Including Strength (mg)	Dose/Frequency	
	/	
	/	
	/	
	/	
	/	
	/	
ALLERGIES: *LIST BELOW*	_______*NO KNOWN DRUG ALLERGIES*	

SOCIAL HISTORY: (Please check one) Smoking Status:

DAILY_______ OCCASIONAL________ FORMER________ NEVER________

OTHER FAMILY HISTORY (ie cancer/diabetes/high blood pressure/thyroid/skin cancer/none):

REVIEW OF SYSTEMS:	Are you currently experiencing any of the following?	
	YES	NO
Problems with healing or scarring		
Joint Aches		
Fever or Chills		
Depression or Anxiety		
Headaches		
Cough		
Hay Fever or Asthma		
Dry Eyes		
Thyroid Problems		
Problems with Healing		
Changing Mole		
RASH		
Allergy to topical antibiotics		
Allergy to lidocaine		
Allergy to adhesive		
Aspirin or Blood Thinners		
Artificial Joint Replacement		
Pregnancy/Planning a pregnancy?		
Pacemaker or Defibrilator		
GI Upset with antibiotics		
Rapid heartbeat with epinephrine		
Premedicaton prior to procedures		
Artificial heart valve		
Other Symptoms:		

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RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

WRITTEN ACKNOWLEDGEMENT FORM

ALL PATIENTS (Health Insurance and Cosmetic Patients) MUST COMPLETE AND SIGN

I, **(PATIENT'S NAME)**____, have been given the opportunity to review Dermatology and Cosmetic Medicine Specialists Notice of Privacy Practices and acknowledge that it was made available to me as posted on the office website www.drjaygeller.com or in the office when requested by me.

I acknowledge the opportunity to view the terms of the HIPAA policy as posted**.** **I understand** that this consent shall remain in force from this time forward.

(SIGNATURE)____ **DATE**_________________

Signature above is: PATIENT or LEGAL GUARDIAN (if patient is a minor or has a Power of Attorney for medical care)

IMPORTANT: Is there anyone (spouse, parent, son, daughter, etc.) with whom we can discuss your medical condition?

If yes, please PRINT their name(s) and relationship here:

____ ____

NAME/RELATIONSHIP NAME/RELATIONSHIP

OFFICE CANCELLATION POLICY:

We recognize that there are sometimes valid reasons for late cancellations/no shows, and we strive to provide an understanding for specific situations. However, they do place a scheduling, staffing and financial burden on the office and restrict other patients from obtaining timely appointments. Our office has an automated reminder system in place which provides an opportunity to cancel or reschedule two business days prior to your appointment. We also ask that your inform us of any change to your appointment as soon as you are aware, preferably within 24 hours or as early in the day as possible to allow other patients the opportunity for an appointment with us. Our office reserves the right to charge a $75.00 cancellation fee to your account for non-compliance of our policy. Excessive abuse can, but rarely, may result in dismissal from the practice.

I understand that I am expected to pay for all applicable services (non-billable services/Cosmetic procedures/no health insurance) at the time services are rendered in full. If care is provided under health insurance, the SPECIALIST copayment is due at the time of service. All billable insurance balances will be sent to the address on file for my account and are expected by the statement due date unless other arrangements have been set up with our billing staff. It is my responsibility to inform the office of any changes in health insurance, billing address or personal phone numbers when they occur or at the time of check-in. If my insurance requires a referral I also understand that it must be provided at time of appointment to avoid being responsible for the fee's incurred. If at any time the billable balance of my account should become uncollectible, I am responsible for any fees incurred in the collection process.

(SIGNATURE)____ **DATE**_________________

REQUIRED SIGNATURE: PATIENTS USING HEALTH INSURANCE BENEFITS ONLY

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

Release of Information: I authorize the release of any medical information to process my insurance claim when required.

Assignment of Benefits: I authorize payment of medical benefits to Jay D. Geller, MD / Dermatology and Cosmetic Medicine Specialists for any services provided.

(SIGNATURE)____ **DATE** ___________________