complete skin md

PATIENT INFORMATION

First name: _____ Last name: _____

Gender: M○ F○ X○ Marital status: S○ M○ D○ W○

Home street address: _____

City: _____ State: _____ Zip code: _____

Email: _____ DOB: ___/___/____

Home phone: _____ Mobile phone: _____

Work phone: _____ Employer name: _____

Referring MD: _____ Primary care MD: _____

Referral source (if other): _____

Emergency contact: _____

Relationship: _____ Phone: _____

Preferring method of confirmation: Email ○ Text ○ Phone ○

PRIMARY INSURANCE INFORMATION

Carrier: _____ Policy ID #: _____

PHARMACY INFORMATION

As a benefit to our patients, we've partnered with Capsule to offer free same-day prescription delivery to our patients in NYC (all five boroughs) and Westchester; Hoboken, and Jersey City in NJ; and Greenwich and Stamford in CT.

How it works:

1. We send your prescription to Capsule
2. You will download the Capsule app on your phone
3. Capsule will text you within the hour to schedule free same-day delivery (your cell phone number must be your main contact number in our system)
4. Capsule will safely deliver your medication (if prior authorization from your insurance company is required, they will inform you, process the authorization, keep you updated on the status and will deliver once it is approved.

Please indicate if you would prefer to have your medications sent to an alternate pharmacy by listing your preferred pharmacy below with their address and phone number.

Pharmacy name: _____ Phone: _____

Address: _____

_____ _____

Patient signature Date

PATIENT FINANCIAL OBLIGATION

We are dedicated to providing the best possible service to you and regard your complete understanding of your financial responsibilities as an essential element of your treatment and care.

Out-of-Network and Self-Pay Patients: Payment is due at the time of service. As a courtesy to our patients, we will submit your paid claim to your insurance carrier. It is your responsibility to follow up with your carrier regarding your reimbursement. Patients should contact their insurance companies directly for any coverage questions they may have.

Other Bills: If you should undergo a biopsy, culture, or blood test in our office, your insurance carrier will be billed separately by the Lab. You will receive a separate bill from the Lab for any uncovered charges.

CREDIT CARD INFORMATION

I authorize CompleteSkinMD to charge balances on the account of _____ to the credit card listed below.

My signature is recognized by the credit card issue as valid transactions.

_____ _____

Patient signature Date

Account type: Visa ○ MasterCard ○ AMEX ○ Discover ○

Cardholder name: _____

Account number: _____

CVV2 (3-digit number on back of Visa/MC; 4 digits on front of AMEX): _____ **Expiration:** _____

Billing address: _____

City, state, ZIP: _____

It is our utmost concern that patients' transactions are processed according to the highest standards. To that end, CompleteSkinMD will safely and securely store your credit card information on Authorize.net, the industry leader in gateway security. This method meets all PCI requirements. All card information will be stored in an Authorize.net "Lock Box" and truncated during the process to prevent unauthorized access to full card information.

VACCINATION INFORMATION

Are you fully vaccinated? Yes ○ No ○

If yes, name of vaccine: _____

Dates of dosages: First ___/___/___ Second ___/___/___ Third (booster) ___/___/___

PATIENT HISTORY

Name: _____ Date: _____

DOB: ___/___/____

PAST MEDICAL HISTORY

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial joints
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ BPH
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ BRCA positive
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Deep vein thrombosis
- ☐ Depression
- ☐ Diabetes Type I ☐ Type II ☐
- ☐ End Stage Renal Disease
- ☐ GERD (Acid Reflux)
- ☐ Hearing Loss
- ☐ Hepatitis A ☐ B ☐ C ☐ Unknown ☐
- ☐ Herpes Simplex (Fever Blisters)
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ IBD (Crohn's, Colitis)
- ☐ IBS
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Migraine headaches
- ☐ Organ Transplant _____
- ☐ Pacemaker
- ☐ Prostate Cancer
- ☐ Pulmonary Embolism
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke Valve
- ☐ Replacement
- ☐ None
- ☐ Other _____

MEDICATIONS (Please enter all current medications)

ALLERGIES (Please enter all allergies and reactions)

☐ No known allergies to medication

Do you require pre-medication with an antibiotic prior to routine dental work (e.g., cleaning)? Yes ◯ No ◯
If yes, indication: _____

Do you have a pacemaker)? Yes ◯ No ◯

Do you have a defibrillator)? Yes ◯ No ◯

PAST SURGICAL HISTORY

- ☐ Angioplasty
- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Coronary Artery Bypass
- ☐ Mastectomy (Right ☐ Left ☐ Bilateral ☐)
- ☐ Lumpectomy
- ☐ Breast Biopsy
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Cesarean Section
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ Heart Transplant
- ☐ Joint Replacement, Knee
- ☐ Joint Replacement, Hip
- ☐ Joint Replacement Date ___/___/____
- ☐ Kidney Biopsy
- ☐ Kidney Removed (Right ☐ Left ☐)
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ Spleen Removed
- ☐ Testicles Removed
- ☐ Valve Replacement
- ☐ Type: _____
- ☐ Date: ___/___/____
- ☐ None
- ☐ Other _____

SKIN DISEASE HISTORY

- ☐ Acne
- ☐ Actinic Keratoses (precancers)
- ☐ Basal Cell Carcinoma
- ☐ Blistering Sunburns
- ☐ Eczema
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Merkel Cell Carcinoma
- ☐ Mohs Surgery
- ☐ MRSA
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma
- ☐ None
- ☐ Other _____

Are you currently using any medications prescribed for your skin)? Yes ☐ No ☐
If yes, specify: _____

Do you wear Sunscreen)? Yes ☐ No ☐ Sometimes ☐
If yes, what SPF? _____
Have you ever used a tanning salon? Yes ☐ No ☐
Current? Yes ☐ No ☐
Have you had blistering sunburns? Yes ☐ No ☐
Do you react to anesthesia? Yes ☐ No ☐
Do you react to anesthesia? Yes ☐ No ☐
Do you react to bandages / adhesives? Yes ☐ No ☐
Do you heal with thick (keloid) scars? Yes ☐ No ☐

Do you have a family history of melanoma? Yes ○ No ○
If yes, which relative(s) ?

Do you have a family history of non-melanoma skin cancer? Yes ○ No ○
If yes, which relative(s)?

Any other family history of cancer:

Mother: Alive ○ Deceased ○ Age ____ Father: Alive ○ Deceased ○ Age ____

Are you pregnant? Yes ○ No ○
Are you nursing? Yes ○ No ○

Number of children: ____ Age(s): ____

SOCIAL HISTORY

Cigarette smoking:
- ○ Never smoked
- ○ Quit: Former smoker
- ○ Smokes less than daily
- ○ Smokes daily

Alcohol Use?
- ○ Yes
- ○ No

Language:
- ○ English
- ○ Spanish
- ○ Other ____

Race:
- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ American Indian or Native Alaskan
- ☐ Native Hawaiian / Pacific Islander

How often do you exercise?
- ○ Once a day
- ○ Few times a week
- ○ Few times a month
- ○ Never

What is your caffeine use?
- ○ Once a day
- ○ Few times a week
- ○ Few times a month
- ○ Never

Please let us know about your current skin care regime. Kindly list products and brands. Thank you.

A.M.:

P.M.:

PRIVACY NOTICE ACKNOWLEDGEMENT

Name: _____
(Last) **(First)** **(Middle)**

I understand that CompleteSkinMD ("The Practice") may use my health information for treatment, payment, and health care operations. I have been shown a copy of the Practice's Notice of Privacy practices (the "Notice") that describes how my information may be used and disclosed. I understand that the Practice has the right to change this Notice at any time. I may obtain a current copy of the Notice by contacting the Practice at (212) 759-4900.

_____ _____
Signature of Patient / Parent / Legal guardian or Personal Representative **Date**

_____ March 20, 2014
If signed by a Personal Representative, relationship to patient Privacy Notice Effective Date