Advanced Dermatology, Mohs and Laser Surgery Center, P.A.

240 East Grove Street
Westfield, NJ 07090-1687
Phone: (908) 232-6446
Fax: (908) 232-6447
www.skinandlasercenter.com

Appointment Date: _____

Time: _____

Doctor: _____

Physician Assistant: _____

Dear Patient:

Thank you for scheduling an appointment with our office. We invite you to register for our patient portal at **https://advanceddermnj.ema.md**. Please use this portal to update your medications and health history prior to your appointment, as well as access your patient record in the future. If you provided your email address to us, you should have received an invitation to register. If you need us to resend the invitation, please give us a call. If you do not have an email address, please call our office and we can create a login for you. **Please remember to press "Save and Continue" as you answer all the health history questions.**

If you are not able to register for our patient portal, please help us by completing the enclosed registration and medical history forms **before** you come to the office. Bring them with you on the day of your appointment. **PLEASE DO NOT MAIL THEM BACK**.

Please be sure to bring your insurance cards, medication list (including dosages) and a photo id to your appointment. We ask that you arrive 15 minutes early for your appointment for registration. If your insurance plan requires a referral, please be sure to bring it with you to your appointment. Knowing whether or not you need to bring a referral is YOUR responsibility.

For insurance plans in which we do not currently participate, your insurance policy is a contract between YOU and YOUR insurance company. If we do not participate with your plan, you will be expected to pay for your visit before leaving our office on the day of your appointment. We accept cash, check, and credit cards.

In order keep wait times to a minimum, we have a 15 minute lateness policy. If you are more than 15 minutes late for your appointment, you will be asked to reschedule your appointment.

Be advised that we do require 24 hour notice for cancellation of your appointment.
Missed office visit charge $50.00.
Missed procedure and surgical visits charge $100.00

We look forward to seeing you.

ADVANCED DERMATOLOGY, MOHS AND LASER SURGERY CENTER, PA.
PLEASE PRESENT THE RECEPTIONIST WITH ALL OF YOUR INSURANCE CARDS

FIRST NAME: _____ **MI:** _____ **\LAST NAME:** _____

ADDRESS: _____

_____

CITY: _____ **STATE:** _____ **ZIP:** _____-_____

DATE OF BIRTH: _____/_____/_____

HOME #: (_____) _____-_____ **WORK #:** (_____) _____-_____ **CELL #** (____) _____-_____

EMAIL ADDRESS: _____

GENDER: M / F ***MARITAL STATUS:** SINGLE / MARRIED / DIVORCED/ SEPARATED / WIDOW

RESPONSIBLE PARTY: _____ **PHONE:** (____) _____-_____
(I.E. PARENT/GUARDIAN)

***IF PRIMARY INSURED IS A PERSON OTHER THAN THE PATIENT (I.E. PATIENT IS SPOUSE OF POLICY HOLDER, OR A CHILD) PLEASE COMPLETE THE PRIMARY INSURED INFORMATION SECTION OF THIS FORM.*

PRIMARY INSURANCE CO: _____ **ID#** _____

PRIMARY INSURED (POLICYHOLDER): _____

SECONDARY INSURANCE CO: _____ **ID#** _____

PRIMARY INSURED (POLICYHOLDER): _____

TERTIARY INSURANCE CO: _____ **ID#** _____

PRIMARY INSURED (POLICYHOLDER): _____

**PRIMARY INSURED

(COMPLETE THIS SECTION WHEN THE INSURANCE POLICY HOLDER IS A PERSON OTHER THAN THE PATIENT. EXAMPLES OF THIS IS WHEN THE INSURANCE POLICY HOLDER IS THE PARENT, LEGAL GUARDIAN, OR SPOUSE OF THE PATIENT)

PRIMARY INSURANCE

FIRST NAME: _____ MI: _____
LAST NAME: _____
ADDRESS: _____
_____
_____
HOME PHONE: (_____) _____- _____
WORK PHONE: (_____) _____-_____
DATE OF BIRTH (MM/DD/YYYY): ____/____/_____
GENDER: *(CIRCLE ONE)* MALE / FEMALE
RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE

FIRST NAME: _____ MI: _____
LAST NAME: _____
ADDRESS: _____
_____
_____
HOME PHONE: (_____) _____- _____
WORK PHONE: (_____) _____-_____
DATE OF BIRTH (MM/DD/YYYY): ____/____/_____
GENDER: *(CIRCLE ONE)* MALE / FEMALE
RELATIONSHIP TO PATIENT:

I AUTHORIZE THE RELEASE TO ANY REFERRING PHYSICIAN OR APPROPRIATE INSURANCE COMPANY ANY MEDICAL INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

SIGNATURE: _____ DATE: _____

Advanced Dermatology, Mohs & Laser Surgery Center, P.A.

Health History Form

Name: _____ Date: _____

Street Address: _____ City / State: _____

Zip Code: _____ Date of Birth: _____ Age: _____ Gender: _____

Phone Number (preferred): _____ Phone Number (alternate): _____

Email Address: _____

Emergency Contact: _____ (Relationship) _____ (Phone) _____

Preferred Language: _____ Race: _____

Ethnic Group: (Circle one) Declined / Hispanic or Latino / Not Hispanic or Latino

Occupation: _____ Marital Status: M/ S/ W/ D (Circle one)

Employer: _____

Preferred Pharmacy

Name: _____

Phone Number: _____

City or Zip Code: _____

Primary Care Doctor

Name: _____

Phone #: _____

City or Zip Code: _____

☐ - **Check here to provide consent for us to download medication history from your pharmacy.**

If you were referred here by another provider, please provide name and contact info: _____

_____

Past Medical History

Select any of the following medical conditions you currently have, if none, check NONE:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bleeding/Easy Bruising
- ☐ Bone Marrow Transplant
- ☐ BPH (enlarged prostate)
- ☐ Breast Cancer
- ☐ History of Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Defibrillator
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other

_____

_____

_____

Alerts

☐ allergy to adhesive ☐ allergy to lidocaine ☐ blood thinner ☐ pregnancy/planning pregnancy ☐ pacemaker ☐ allergy to latex
☐ defibrillator ☐ pre-medicate prior to procedure ☐ allergy to topical antibiotic ☐ heart valve/joint replacement

Past Surgical History

Have you had any surgeries on the following organs, if none, check NONE?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Mastectomy (Right, Left, Bilateral)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: Tissue Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Right, Left, Bilateral)
- ☐ Joint Replacement: Knee (Right, Left, Bilateral)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ **NONE**
- ☐ Other

Skin Disease History

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hayfever / Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ **NONE**
- ☐ Other

_____

_____

Do you wear Sunscreen?

○ Yes ○ No

If yes, what SPF? _____

Do you tan in a tanning salon?

○ Yes ○ No

Do you have a family history of Melanoma?

○ Yes ○ No

If yes, which relative?

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter
- ☐ Other

_____

_____

Medications

List all current medications including all dosage information:

Allergies

List all allergies and reactions if known:

Social History

Smoking Status (please choose one):

- ☐ Current everyday smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women?

☐ 0 or ☐ _____(number)

Start Smoking:

- mm/dd/yyyy _____

Quit Smoking:

- mm/dd/yyyy _____

Number of Packs per Day: _____ Total Years Smoking: _____

Family History

Please include only first-degree relatives: indicate which relation(s) on line:

☐ Skin Cancer _____ ☐ Atypical Moles_____ ☐ Pre-Cancers _____

☐ Keloid Scars_____ ☐ Atopy (i.e. allergies, asthma, hay fever, eczema) _____

☐ Skin Disease (Specify): _____ ☐ Other: _____

Review of Systems

Y	N		Y	N		Y	N	
☐	☐	Problems with bleeding	☐	☐	Problems with healing	☐	☐	Problems with scarring (hypertrophic/keloid)
☐	☐	Rash	☐	☐	Immunosuppression	☐	☐	Hay fever
☐	☐	Chest Pain	☐	☐	Fever or Chills	☐	☐	Night Sweats
☐	☐	Loss of Appetite	☐	☐	Unintentional weight loss	☐	☐	Thyroid problems
☐	☐	Sore throat	☐	☐	blurry vision	☐	☐	Abdominal pain
☐	☐	Bloody stool	☐	☐	bloody urine	☐	☐	Joint aches
☐	☐	Muscle weakness	☐	☐	neck stiffness	☐	☐	Headaches
☐	☐	Seizures	☐	☐	cough	☐	☐	Shortness of breath
☐	☐	Wheezing	☐	☐	anxiety	☐	☐	Depression
☐	☐	Fatigue						

Immunizations/Vaccines

Y	N		Y	N	
☐	☐	Influenza	☐	☐	Pneumonia

Advance Care

Y	N	
☐	☐	Do you have a health care proxy in the event you are unable to make your own medical decisions? If yes, Name: _____ Phone # _____
☐	☐	Do you have a living will?

Which statement best reflects your wishes on advanced care recommendations?

☐ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

☐ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.

☐ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made

This is a confidential record of your medical history. Information contained here will not be released to any person except who you have authorized us to do so.
I authorize the release to any referring physician or appropriate insurance company any medical information acquired in the course of my examination or treatment.
To the best of my knowledge, the information on this form has been accurately answered. I understand providing inaccurate information can be dangerous to my (my child's) health. It is my responsibility to inform this office of any changes in my (my child's) medical status. I also authorize the medical staff to perform the necessary health care services that I (my child) may need.

Patient/Guardian Signature: _____

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HIPAA AND PRIVACY

I acknowledge having been offered a copy of the patient's Notice of Privacy Practices. *(Privacy policy may be obtained from the display at the check in window, or on our website at www.skinandlasercenter.com)*

_____ _____ _____

Signature **Date** **Print Your Name**

ALL PATIENTS:

I understand that I am personally
responsible for and, therefore, agree to pay any outstanding balance not covered or paid by my insurance carrier (unless prohibited by contract) including co-payment, co-insurance and/or deductible. I also agree to pay in full for procedures deemed by insurance carriers to be out-of-network or "cosmetic or medically unnecessary" which are not covered by medical insurance.

Patient's Signature_____ **Date**_____

CREDIT CARD COLLECTION POLICY

To Our Patients:
In an effort to streamline patient billing and to avoid collection issues, we have initiated a policy, in which our office retains a credit card on file. Your credit card information is securely encrypted and stored, just like it would be at a hotel.
After applying your co-pay and/or all insurance payments and adjustments, you will be billed for any balance owed. You will have 30 days to pay the balance of your bill via cash, credit, check or money order. If you have not paid your balance within 30 days of the statement date, we will process payment via your credit card on file for the balance due.
The payment applied to your credit card will NOT be more than the total charge for services rendered.

If you decide to pay your bill via another method after we charge your card, please contact the office for those payment arrangements, and we will refund your card on file. If you initiate a charge back through your credit card company, we will be charged a fee by the bank and will pass that fee on to you.

Thank you for your cooperation in this matter. We value your business and will protect your privacy at all times. If you have any questions, please contact our billing department.

Thank you.
I authorize Advanced Dermatology, Mohs & Laser Surgery Center, P.A. to charge my credit card for balances due on my account.

PATIENT SIGNATURE: _____ DATE: _____

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Designation of Certain Relatives, Close Friends and Other Caregivers

I agree that Advanced Dermatology, Mohs and Laser Surgery Center may disclose my health information to a family member, close personal friend, or other caregiver because such person is involved with my healthcare or payment relating to my healthcare. In that regard, Advanced Dermatology, Mohs and Laser Surgery Center will disclose only information that is directly relevant to the named person's involvement with my healthcare or payment relating to my healthcare.

I designate the following persons listed below as persons involved with my healthcare or payment relating to my healthcare. I understand that I am not required to list anyone. I also understand that I may change this list, in writing, at any time.

Print Name	Relationship	Date of Birth	Telephone #
Print Name	Relationship	Date of Birth	Telephone #
Print Name	Relationship	Date of Birth	Telephone #
Print Name	Relationship	Date of Birth	Telephone #

Patient Signature

Date