HISTORY & INTAKE FORM

Past Medical History: (Check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ BPH
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Pacemaker
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Valve Replacement
- ☐ None
- ☐ Other _____

- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ PTCA
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement,Knee [Right, Left, Bilateral]
- ☐ Joint Replacement,Hip [Right, Left, Bilateral]
- ☐ Joint Replacement within last 2 years
- ☐ 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
- ☐ TURP
- ☐ Skin Biopsy
- ☐ Basal Cell Cancer Surgery
- ☐ Squamous Cell Carcinoma Surgery
- ☐ Melanoma surgery
- ☐ Spleen Removed
- ☐ Testicles Removed [Right, Left, Bilateral]
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ None
- ☐ Other _____

Past Surgical History: (Check all that apply)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy [Right, Left, Bilateral]
- ☐ Lumpectomy [Right, Left, Bilateral]
- ☐ Breast Biopsy [Right, Left, Bilateral]
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis

Skin Disease History: (check all that apply)

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basil Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/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(s)? _____

Cautions: (please circle all that apply)

Have you ever had difficulty stopping bleeding? Yes No
Do you require antibiotics prior to a surgical procedure? Yes No
Have you had an artificial joint replacement? Yes No
If yes, when and what body locations? _____ Yes No
Do you have an artificial heart valve? Yes No
Do you have a pacemaker? Yes No
Do you have a defibrillator? Yes No
Are you pregnant or currently trying to get pregnant? Yes No

Medications: (Please enter all current medications)

_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____

Review of Systems: Are you currently experiencing any of the following symptoms? (please check all that apply)

- ☐ Abdominal Pain
- ☐ Anxiety
- ☐ Bleeding Problems
- ☐ Bloody Stool
- ☐ Bloody Urine
- ☐ Blurry Visiion
- ☐ Changing Mole
- ☐ Chest Pain
- ☐ Cough
- ☐ Depression
- ☐ Fever or Chills
- ☐ Headaches
- ☐ Hay Fever
- ☐ Joint Aches
- ☐ Muscle Weakness
- ☐ Neck Stiffness
- ☐ Night Sweats
- ☐ Rash
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Sore Throat
- ☐ Thyroid Problems
- ☐ Unintentional Weight Loss
- ☐ Wheezing
- ☐ Other Symptoms:

PLEASE SIGN_____

Symptom: (Please check all that apply)

- ☐ Abdominal Pain
- ☐ Anxiety
- ☐ Bleeding Problems
- ☐ Bloody Stool
- ☐ Bloody Urine
- ☐ Blurry Visiion
- ☐ Changing Mole
- ☐ Chest Pain
- ☐ Cough
- ☐ Depression
- ☐ Fever or Chills
- ☐ Headaches
- ☐ Hay Fever
- ☐ Joint Aches
- ☐ Muscle Weakness
- ☐ Neck Stiffness
- ☐ Night Sweats
- ☐ Rash
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Sore Throat
- ☐ Thyroid Problems
- ☐ Unintentional Weight Loss
- ☐ Wheezing
- ☐ Other Symptoms:

_____

Social History: (Please check all that apply)

- ☐ Currently Smokes
- ☐ Has smoked in the past
- ☐ Drug Use
- ☐ None
- ☐ Other _____

****

Official Use only

Date /Initials	**Date /Initials**	**Date /Initials**	**Date /Initials**

PLEASE SIGN:_____

DATE:_____

North Jersey Dermatology Center, P.C.

Joseph M. Masessa, M.D., F.A.A.D.

PLEASE NOTE: IT IS THE PATIENT'S RESPONSIBILITY TO KNOW WHICH LAB THEIR INSURANCE COMPANY IS AFFILIATED WITH.

OFFICE POLICY & PATIENT RESPONSIBILITY

I. Your insurance coverage is a contract between you, the patient, and your insurance company (not the doctor).

A. Deductible is the patient's responsibility; even Medicare has a $131.00 deductible.

B. Co-insurance/co-payments are the patient's responsibility.

C. Co-payment is due at the time of the visit.

D. Referrals, if required, are the patient's responsibility. **YOU WILL NOT BE SEEN IF YOU DO NOT HAVE THE PROPER REFERRAL.** You may reschedule your appointment.

E. Filing insurance claims is a service provided without charge and in no way relieves you of responsibility of your bill.

F. We accept assignment with all insurance companies and Medicare. We do not accept Medicaid.

II **NOTE:** **ASSIGNMENT MEANS: WE ALLOW YOUR INSURANCE COMPANY TO DISCOUNT THE CHARGES. YOUR INSURANCE COMPANY WILL SET THE FEES FOR THE PROCEDURES PERFORMED. THESE FEES WILL REFLECT THEIR CUSTOMARY AND REASONABLE CHARGES AND ARE THE PATIENT'S RESPONSIBILITY.**

(Continued on Page 2)

EXAMPLE: If your insurance company pays 80% of covered/discounted charges, the patient is responsible for 20% of covered/discounted charges. The 20% is called the co-insurance.

If you have secondary insurance, we will submit the 20% for reimbursement.

Any charge your insurance company deems to be over reasonable and customary is not patient responsibility and will be adjusted accordingly.

III Your insurance company states these are the patient's responsibility and payments are due immediately.

A. Charges applied to your deductible
B. Charges applied to co-insurance
C. If you do not reply to your insurance company's requests for further information required to process the claim
D. If your coverage is not in effect at time of visit
E. If there are charges in coverage which you did not advise the doctor's office prior to the visit
F. If your coverage does not cover specific procedures as specified in your insurance handbook
G. If the insurance payments are sent directly to you, you are responsible for sending them to the office with the Explanation of Benefits (EOB)

IV Our goal is to provide the best medical care available while allowing your insurance company to establish customary and reasonable fees.

V Responsible Parent: In cases of divorced or separated parents, our policy is that the patient bringing the child into our office must be responsible for the full payment of all fees.

I HAVE READ AND COMPLETELY UNDERSTAND THE ABOVE OFFICE POLICY AND PATIENT RESPONSIBILITY.

_____ _____

Patient/Guardian Date

526 Bloomfield Avenue, Suite 202, Caldwell, New Jersey 07006
973-521-7347 (telephone); 973-521-7905 (fax)

925 Clifton Avenue – Suite 207, Clifton, New Jersey 07013
973-955-4800 (telephone); 973-955-4804 (fax)

7 Oak Ridge Road, Newfoundland, New Jersey 07435
973-208-8110 (telephone); 973-208-8106 (fax)

1116 Route 46, Parsippany, New Jersey 07054
973-917-3700 (telephone); 973-917-3702 (fax)

35 Green Pond Road, Rockaway New Jersey 07866
973-625-0600 (telephone); 973-625-0336 (fax)

655 Kearny Avenue, Suite 103, Kearny, New Jersey 07032
201-428-1938 (telephone); 551-580-7307 (fax)

North Jersey Dermatology Center, PC

TO ALL PATIENTS:

If your insurance company requires a referral from your primary doctor, you must have it with you at the time of your visit. It is also the patient's responsibility to keep track of how many visits you have used on your referral and when it expires.

If you do not have a referral with you at the time of your appointment, we will not be able to see you and will reschedule your appointment.

This office cannot follow up with everyone's insurance company to check on individual referrals. THIS IS THE PATIENT'S RESPONSIBILITY.

Also, if you need a surgery or special procedure, we will check with your insurance company to see if a pre-certification is needed but it is the patient's responsibility to check with the insurance company regarding your benefits, co-pays, deductibles and what percentage you are responsible for paying.

Please sign the following:

I understand that any fees not covered by my insurance company, such as co-pays and deductibles, will be my responsibility to pay to North Jersey Dermatology Center, P.C.

_____ _____

Patient's Signature Date

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North Jersey Dermatology Center, P.C.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for North Jersey Dermatology Center, P.C., to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent.

North Jersey Dermatology Center, P.C., reserves the right to revise its Notice of Privacy Practices at anytime. A revise Notice of Privacy Practices may be obtained by forwarding a written request to North Jersey Dermatology Center, P.C., Privacy Officer at: 35 Green Pond Road, Rockaway, New Jersey 07866.

With this consent, North Jersey Dermatology Center, P.C., may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, North Jersey Dermatology Center, P.C., may mail to my home or other alternative location any North Jersey Dermatology Center, P.C., items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. I have the right to request that North Jersey Dermatology Center, P.C., restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

BY SIGNING THIS FORM, I AM CONSENTING TO NORTH JERSEY DERMATOLOGY CENTER, P.C.'S USE AND DISCLOSURE OF MY PHI TO CARRY OUT TPO.

I MAY REVOKE MY CONSENT IN WRITING EXCEPT TO THE EXTENT THAT THE PRACTICE HAS ALREADY MADE DISCLOSURES IN RELIANCE UPON MY PRIOR CONSENT. IF I DO NOT SIGN THIS CONSENT, OR LATER REVOKE IT, NORTH JERSEY DERMATOLOGY CENTER MAY DECLINE TO PROVIDE TREATMENT TO ME.

(Detach above and give to patient for their records)

I ACKNOWLEDGE READING THE PRIVACY PRACTICE NOTICE ABOVE AND HAVE SIGNED BELOW TO ACCEPT.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Patient's Name Print Name of Patient or Legal Guardian

526 Bloomfield Avenue, Suite 202, Caldwell, New Jersey 07006
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973-625-0600 (telephone); 973-625-0336 (fax)

OFFICE POLICY

AT TIME OF BIOPSY, YOU ARE REQUIRED AS OUR PATIENT TO SCHEDULE A FOLLOW UP OFFICE VISIT WITHIN (4-8) WEEKS TO REVIEW YOUR PATHOLOGY RESULTS. THIS ALSO ENSURES THAT YOUR RESULTS HAVE BEEN RETURNED FROM THE LAB.

_____ _____

Signature of Patient/ Authorized Guardian Date

526 Bloomfield Avenue, Suite 202, Caldwell, New Jersey 07006
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