# North Jersey Dermatology Center, PC

## HISTORY & INTAKE FORM

**Past Medical History: (Check all that apply)**

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ 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 _____

**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
- ☐ 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 _____

**Skin Disease History: (check all that apply)**

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Basal 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

**Social History: (Please check all that apply)**

- ☐ Currently Smokes
- ☐ Has smoked in the past
- ☐ Drug Use
- ☐ 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 Vision
- ☐ 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:

Ethnicity _____
Race _____
Language _____

**NAME OF PATIENT:** _____
**SIGNATURE OF PATIENT/LEGAL GUARDIAN:** _____
**DATE:** _____

**********

Official Use only

| Date /Initials | Date /Initials | Date /Initials | Date /Initials |
|---|---|---|---|
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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, PC, 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, PC, 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, PC, Privacy Officer, 35 Green Pond Road, Rockaway, New Jersey 07866.

With this consent, North Jersey Dermatology Center, PC, 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, PC, may mail to my home or other alternative location any North Jersey Dermatology Center, PC, 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, PC, 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, PC'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, PC, MAY DECLINE TO PROVIDE TREATMENT TO ME.**

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(Sign in duplicate and provide patient with copy for their records)

**I ACKNOWLEDGE READING THE PRIVACY PRACTICE NOTICE ABOVE AND SIGN BELOW TO ACCEPT.**

**Name of Patient:** _____

_____ _____

**Signature of Patient/Legal Guardian** **Date**

# *North Jersey Dermatology Center, P.C.*

## OFFICE POLICY & PATIENT RESPONSIBILITY REGARDING PAYMENTS

Your insurance coverage is a contract between YOU AND YOUR INSURANCE COMPANY (not this office). As such, you acknowledge and agree that:

A. Payment of your deductible is your responsibility (even Medicare has a deductible).
B. Co-payments are your responsibility and are due at the time of your visit.
C. Co-insurance payments are your responsibility. ***Example***: If your insurance company pays 80-% of covered/discounted charges, you will be 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.
D. Referrals, if required are the responsibility of the patient. YOU WILL NOT BE SEEN if you do not have the proper referral, and will need to reschedule.
E. Filing insurance claims is a service provided by this office without charge and in no way relieves you of the financial responsibility of paying your bill. It is your responsibility to provide us with your current insurance information. Additionally, it is your responsibility to confirm that your insurance coverage is in effect at the time of your visit and to respond to your insurance company's request for any additional information needed from you to process claim.
F. We accept assignment with most insurance companies and Medicare. We DO NOT accept New Jersey State Medicaid, however we do participate with most Medicaid HMO plans.
G. You are responsible for forwarding to our office any payments sent directly to you by your insurance company, along with the EOB (Explanation of Benefits).
H. It is your responsibility to advise this office which lab your insurance company is affiliated with.
I. In cases divorced or separated parents, our policy is that the parent accompanying the child to the office visit is responsible for full payment of all fees.

I am in agreement with the office policy and patient responsibility set forth above:

_____
NAME OF PATIENT

_____
SIGNATURE OF PATIENT AND/OR LEGAL GUARDIAN

_____
DATE

# 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 your 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 your insurance company to check on individual referrals. THIS IS YOUR RESPONSIBILITY. If seen without referral, the balance will be 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 your responsibility to check with your insurance company regarding your benefits, co-pays, co-insurance, deductibles and what percentage you are responsible for paying.

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

**Name of Patient:** _____

_____ _____

**Signature of Patient/Legal Guardian** **Date**

# OFFICE POLICY

*North Jersey Dermatology Center, P.C.*

**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.**

**Name of Patient:** _____

_____ _____

**Signature of Patient/Legal Guardian** **Date**