NEW ENGLAND DERMATOLOGY & LASER CENTER

Name:_____
Date of Birth:_____
Chart:_____
Date: _____

The physicians and staff of New England Dermatology & Laser Center value and appreciate your selection of our office for your skin care. We are committed to providing you with the best possible service. A clear understanding of our office policy is important to our professional relationship.

INSURANCE AND MANAGED CARE

We participate in most insurance plans. Please inquire upon check-in to see if we accept your plan to avoid billing problems later. If your insurance plan requires a referral, you must have a valid referral on file from your primary care physician. If your visit has not been authorized, you have the option of signing a waiver making you financially responsible for that visit or rescheduling your appointment until such time as your visit is authorized.

APPOINTMENT CANCELING POLICY

We kindly ask for 24 hours notice if you cannot keep your scheduled appointment so that we may fill that opening. We reserve the right to charge a $25.00 Missed Appointment fee if you do not cancel within that time frame.

Please initial _____.

COSMETIC REMOVAL OF BENIGN LESIONS

A benign lesion is a spot or growth which in the physician's opinion is not cancerous or pre-cancerous and for which there is no medical reason to treat. Insurance companies will pay for the evaluation of these lesions, but will not pay for their removal. Lesions which may fall into this category include: certain moles, brown spots (so called "liver" or "age" spots), angiomas (blood vessel moles and "broken" blood vessels), seborrheic keratoses (warty moles), skin tags (small flaps of skin found around eyelids, neck, under arms, under breasts, and in groin), and milia (persistent whiteheads) on face and eyelids. If you have a benign growth which you would like to have removed, you must sign a "waiver of liability" agreeing to be personally and financially responsible and payment is expected at the time of treatment.

If you have any questions, please feel free to inquire before signing below.

I have read and understand the above policies.

Patient signature _____ Date _____

Guarantor signature (if guarantor is not the patient) _____ Date _____

NEW ENGLAND DERMATOLOGY & LASER CENTER

Name:_____
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Patient Authorization for Treatment, Payment & Photographs

ALL PATIENTS:

- I hereby authorize medical/surgical treatment, care and/or services by New England Dermatology & Laser Center and authorize payment directly to New England Dermatology & Laser Center for all medical/surgical benefits, if any, that may be payable to me under the terms of my health insurance policy. I fully understand that I am primarily and financially responsible for fees incurred and that payment to New England Dermatology & Laser Center is not contingent on any settlement, judgment, or verdict by which I eventually recover medical fees.
- I hereby consent to and authorize New England Dermatology & Laser Center to use and disclose any of my health information, including my medical records and prescription medical history, for purposes concerning my treatment, payment for health care provided to me or the health care operations of New England Dermatology & Laser Center or other treating health care provider or plan.

Signature of patient or guardian _____ Date _____

PHOTOGRAPHS:

I give New England Dermatology & Laser Center permission to take clinical photographs for my medical record. I understand that the photographs remain the property of the office and may be used anonymously for the purpose of furthering medical education.

Signature of patient or guardian:_____

Acknowledgement of Receipt of Notice of Privacy Practices

It is the policy of New England Dermatology & Laser Center to provide all patients, or their parents, guardians or personal representatives, a copy of our current Notice of Privacy Practices prior to the date of the first service delivery, or upon the first visit to New England Dermatology & Laser Center after April 14, 2003, if feasible. This signed acknowledgement is to be filed in the medical record.

I have received New England Dermatology & Laser Center's Notice of Privacy Practices

Signature of patient or guardian _____ Date _____

Authorization to Disclose Protected Health Information to family, friends, and/or others

By signing below, I have authorized New England Dermatology & Laser Center to disclose my Personal Health Information to the following family or others:

Name: _____ relationship_____ telephone # _____
Name: _____ relationship_____ telephone # _____
Name: _____ relationship_____ telephone # _____
Name: _____ relationship_____ telephone # _____

Please complete YOUR personal contact information below:

Home Phone: _____May we leave a message on your answering machine? _____
Work Phone: _____ May we leave a message on your answering machine? _____
Cell Phone: _____ May we leave a message or auto message on your VM? _____
E-mail: _____May we email a message to you? _____

You are required to state how long this consent is valid for: _____ one year _____ two years _____ three years
You may revoke this authorization at any time by stating in **writing** to our Privacy Officer.

Patient or guardian signature: _____ Date: _____

NEW ENGLAND DERMATOLOGY & LASER CENTER

Name:_____
Date of Birth:_____
Chart:_____
Date: _____
Initial HX _____ Updated HX _____

PATIENT PROFILE - REVIEW OF SYSTEMS

Name - How would you like to be addressed? _____ Age: _____

Occupation: _____ Preferred language: _____

Gender Identity: ❑ male ❑ female ❑ other ❑ prefer not to specify

Marital Status: ❑ single ❑ married ❑ widowed ❑ divorced ❑ partner ❑ prefer not to specify

Primary care provider: _____ Location:_____

Have you ever been a patient in our office? ❑ Yes ❑ No If yes, how long ago? _____

What was the reason? _____

WHAT IS THE REASON FOR YOUR VISIT TODAY? _____

Referred by: ❑ self ❑ primary care provider ❑ other

Please **LIST** and **DESCRIBE** any **ALLERGIES** and/or **ADVERSE REACTIONS** you have had to any medications, foods, plants, latex, or any other products. ❑ None

_____ _____ _____

_____ _____ _____

Please list **ALL MEDICATIONS, PRESCRIPTIONS** and/or **NON-PRESCRIPTION MEDICATION** including herbals, nutritional supplements, homeopathic, aspirin, Tylenol, Advil, oral contraceptive, IUD, hormones, allergy shots, vitamins, laxatives, pills taken regularly for: headache, arthritis, nerves, sleeping, pain, etc. ❑ No Medications
❑ See attached list

_____ _____ _____

_____ _____ _____

_____ _____ _____

CRITICAL INFORMATION:

❑ Yes ❑ No Have you had any REACTIONS TO LOCALLY INJECTED ANESTHESIA, NOVACAINE OR XYLOCAINE received at the dentist? If yes, what was the reaction: _____

❑ Yes ❑ No Have you had SKIN REACTIONS TO LATEX, BAND AIDS, ADHESIVE TAPE, ANTIBIOTIC OINTMENTS OR CREAMS? Please circle if applicable reactions.
If yes, please explain: _____

❑ Yes ❑ No Have you had DIFFICULTY WITH PROLONGED WOUND HEALING, ABNORMAL SCARRING OR KELOIDS?

❑ Yes ❑ No Do you have a PACEMAKER, DEFIBRILLATOR, COCHLEAR IMPLANT, OR NERVE STIMULATOR? Please circle if applicable.

❑ Yes ❑ No Do you have an ARTIFICIAL HEART VALVE?

❑ Yes ❑ No Have you had BACTERIAL ENDOCARDITIS (heart valve infection)?

❑ Yes ❑ No Do you have ARTIFICIAL JOINTS? If yes, list joint and date:
Joint: _____ Date:_____ Joint:_____ Date: _____
Joint: _____ Date: _____ Joint:_____ Date: _____

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Date: _____

❑ Yes ❑ No Have you been advised to take ANTIBIOTICS BEFORE SURGERY OR DENTAL PROCEDURES?
If yes, what do you take? _____

❑ Yes ❑ No Do you have a TENDENCY TO BLEED OR BRUISE EASILY after dental procedures or other injury?

❑ Yes ❑ No Do you take WARFARIN, ASPIRIN, OR OTHER BLOOD THINNING MEDICATIONS?

❑ Yes ❑ No Do you suffer from ANXIETY? If yes, are you receiving treatment? ❑ Yes ❑ No

❑ Yes ❑ No Are you FEARFUL OF NEEDLES?

❑ Yes ❑ No Are you on CHEMOTHERAPY, OTHER IMMUNOSUPPRESSIVE OR OTHERWISE SUSCEPTIBLE TO FREQUENT INFECTIONS?

❑ Yes ❑ No Have you had STAPH or MRSA bacterial infections?

❑ Yes ❑ No Do you or have you had HIV, HEPATITIS A, B, OR C, TUBERCULOSIS, OR OTHER COMMUNICABLE DISEASE? Please circle if applicable. ❑ Decline to answer.
If yes, please explain: _____

❑ Yes ❑ No Do you or have you had HERPES INFECTIONS (cold sores)?
If yes, do you have treatment available? ❑ Yes ❑ No

❑ Yes ❑ No Do you or have you had a SEXUALLY TRANSMITTED DISEASE (genital herpes, genital warts, syphilis, gonorrhea, lice, other? Please circle if applicable. ❑ Decline to answer.

❑ Yes ❑ No Have you ever FAINTED? If yes, what were the circumstances: _____

Female patients:
❑ Yes ❑ No Are you PREGNANT? If yes, due date: _____
❑ Yes ❑ No Are you currently BREAST FEEDING?
❑ Yes ❑ No Are you PLANNING TO BECOME PREGNANT in the coming year?

Check all that apply regarding your health:

Heart
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart failure
- ☐ Heart attack
- ☐ Heart urgery/Bypass
- ☐ Angina
- ☐ Heart valve disease
- ☐ Mitral valve prolapse
- ☐ Heart murmur
- ☐ Irregular heart rhythm
- ☐ Atrial fibrillation
- ☐ Rheumatic fever
- ☐ Peripheral vascular disease
- ☐ Elevated cholesterol
- ☐ Varicose Veins

Respiratory
- ☐ Short of breath
- ☐ Emphysema
- ☐ Bronchitis

Metabolic
- ☐ Fatigue
- ☐ Weight Loss
- ☐ Regular exercise
- ☐ High/low Thyroid
- ☐ Diabetes
  - ☐ Diet Controlled
  - ☐ Medication
  - ☐ Insulin

Stomach, Bowel, Liver
- ☐ Heartburn
- ☐ Ulcers
- ☐ Colitis/Crohn's
- ☐ Irritable Bowel

Hematologic
- ☐ Enlarged lymph nodes
- ☐ Bleeding disorder
- ☐ Anemia
- ☐ History of blood clot: Site_____

Eye
- ☐ Glaucoma
- ☐ Blindness
- ☐ Poor vision
- ☐ Cataracts
- ☐ Lens implant

Neurologic
- ☐ Migraine Headache
- ☐ Stroke/TIA
- ☐ Numbness
- ☐ Muscle weakness
- ☐ Seizures
- ☐ Dizziness
- ☐ Dementia
- ☐ Alzheimer's Disease

Mental Health
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Schizophrenia
- ☐ Mental health counseling
- ☐ Mental health medications

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Date: _____

- ☐ Phlebitis
- ☐ Hepatitis

Gynecological
- ☐ Regular menses
- ☐ Irregular menses
- ☐ Pre-menopausal
- ☐ Menopausal
- ☐ Oral Contraceptives
- ☐ IUD
- ☐ Ovarian disease
- ☐ Yeast infections

Kidney
- ☐ Stones
- ☐ Kidney Failure
- ☐ Dialysis

Vaccinations
- ☐ Flu
- ☐ Pnuemonia
- ☐ Shingles
- ☐ Hepatitis

Arthritis
- ☐ Rheumatoid
- ☐ Osteoarthritis
- ☐ Psoriatic
- ☐ Lupus
- ☐ Back pain

Allergic Diseases
- ☐ Asthma
- ☐ Hayfever
- ☐ Sinus
- ☐ Hives
- ☐ Allergy shots

Check all that apply:
- ☐ Glasses
- ☐ Hearing aid
- ☐ Dentures
- ☐ Oxygen
- ☐ Cane
- ☐ Walker
- ☐ Wheelchair
- ☐ Stretcher

Cancer (other than skin):

Type: _____ year: _____❑ Surgery ❑ Radiation ❑ Chemo/Immunotherapy ❑ other _____

Type: _____ year: _____❑ Surgery ❑ Radiation ❑ Chemo/Immunotherapy ❑ other _____

Type: _____ year: _____❑ Surgery ❑ Radiation ❑ Chemo/Immunotherapy ❑ other _____

Diseases/other illnesses not listed above: _____

List Surgeries and year:

_____ _____ _____

_____ _____ _____

Race:
- ❑ White
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ Other Race
- ❑ Decline to specify

Ethnic Group:
- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino
- ❑ Unknown
- ❑ Decline to Specify

What is your **NATURAL** eye color: ❑black/brown ❑blue ❑green ❑hazel Height: _____

What is your **NATURAL** hair color: ❑black/brown ❑red ❑blond Weight: _____

Please circle skin type:
- I Always burn, never tan
- II Usually burn, tan minimally
- III Sometimes burn, tan slowly
- IV Burns minimally, tans easily
- V Rarely burns, tans dark easily
- VI Never burns, always tans easily

Regarding your overall sun exposure, do you feel you have had: ❑less than average ❑average ❑more than average

FOR SKIN CANCER PATIENTS:

❑Yes ❑No Have you had an organ transplantation?
❑Yes ❑No Have you had X-ray treatment in the past?
❑Yes ❑No Do you have a history of blistering sunburns in childhood or as an adult?
❑Yes ❑No Do you tend to burn or freckle easily?
❑Yes ❑No Do you wear sunblock/sunscreen or a product that contains one everyday all year round?
❑Yes ❑No Do you have an outdoor occupation or hobby?

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❑Yes ❑No Have you or do you currently go to indoor tanning?

PATIENT AND FAMILY HISTORY FOR SKIN CONDITIONS:
Please check any skin problems you have or had, and if known for family (parents, brothers, sisters):

Family	Patient		
❑	❑	Acne	
❑	❑	Asthma, hayfever, sinus, hives	_____
❑	❑	Eczema	
❑	❑	Psoriasis	
❑	❑	Warts	
❑	❑	Other: _____	

SKIN CANCER HISTORY: **PATIENT SKIN CANCER TREATMENT:**

Family	Patient		Location	Treatment	Year
❑	❑	Precancerous Actinic Keratosis (AK's)			
❑	❑	Basal cell carcinoma			
❑	❑	Squamous cell carcinoma			
❑	❑	Melanoma			
❑	❑	Uncertain type: _____			

SOCIAL HISTORY:

Cigarette Smoking:
- ❑ Current every day smoker
- ❑ Current occasional smoker
- ❑ Former smoker
- ❑ Never smoker

Alcohol use:
- ❑ None
- ❑ Less than 1 drink per day
- ❑ 1 – 2 drinks per day
- ❑ 3 or more drinks per day

Travel: ❑ Yes ❑ No Have you traveled outside of the continental U.S. within the past year?
Pets: ❑ Yes ❑ No Do you have a pet(s)? Please specify:_____

CONTACT INFORMATION:

Which phone number(s) are best to reach you?
□ Home_____May we leave a message at this number regarding your healthcare? □ Yes □ No
□ Cell_____ May we leave a message at this number regarding your healthcare? □ Yes □ No
□ Work_____ May we leave a message at this number regarding your healthcare? □ Yes □ No

Pharmacy:_____ Street/City:_____Phone:_____

Patient/guardian/Healthcare Proxy: _____Date:_____

For office use only: I have reviewed this health information form with the M.A. or provider and documented any changes:

Pt Initial:_____	MA/MD:_____	Date: _____	Pt Initial:_____	MA/MD:_____	Date: _____
Pt Initial:_____	MA/MD:_____	Date: _____	Pt Initial:_____	MA/MD:_____	Date: _____
Pt Initial:_____	MA/MD:_____	Date: _____	Pt Initial:_____	MA/MD:_____	Date: _____

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Pt Initial:_____ MA/MD:_____ Date: _____
Pt Initial:_____ MA/MD:_____ Date: _____

Pt Initial:_____ MA/MD:_____ Date: _____
Pt Initial:_____ MA/MD:_____ Date: _____

New England Dermatology & Laser Center
MACRA Patient Registration Form

In compliance with the HITECH Act to attain MACRA, we are required to obtain certain demographic & health information. This is an important part of your medical history and required for our clinical quality improvement measures. Please complete the information below.

Patient: «PName» **Email:** «PEMail» ❑ No Email

Vaccinations & Health Information:

Have you received a Flu Vaccination in the last year? Yes___ No___

Have you received a Pneumonia Vaccination in the last year? Yes___ No___

Height_____ ft. _____in. Weight_____lbs.

Tobacco Use:

____ Never smoker
____ Former smoker
____ Current every day smoker
____ Current some days smoker
____ Heavy smoker
____ Light smoker

If smoking; number of packs per day: _____
Date started smoking: _____
Date stopped smoking: _____

❑ I allow New England Dermatology & Laser Center to access my prescription medication history from healthcare providers or pharmacies for treatment purposes.
❑ I will **not** allow New England Dermatology to access my prescription medication history allowing them to prescribe appropriately.

Patient or guardian signature: _____ Date: _____