HOW DID YOU HEAR ABOUT US?_____

PATIENT'S NAME _____(FIRST) _____(LAST)

Date of Birth _____ (mm/dd/yyyy)

Social Security Number _____/_____/_____

Gender __Male __Female __Other

Marital Status: Single Married Divorced Widow Other: _____

RACE:

___White __Black or African American __American Indian or Alaska-Native

___Native-Hawaiian or other Pacific Islander ___Asian ___ Other

ETHNICITY: __Hispanic or Latino __Non-Hispanic or Latino

PHONE NUMBERS

Home_____ Cell _____ Work

_____

Preferred phone: __ Home __ Cell __ Work

Is it OK to leave a detailed message? __YES or __NO

Email: _____

Patient's Address: _____

_____

PHARMACY INFORMATION: Name: _____

Address: _____

Phone: _____

INSURANCE: Name: _____

Policy #:_____

PAST MEDICAL HISTORY

Anxiety
Hearing Loss
Arthritis
Hepatitis
Asthma
Hypertension
Atrial Fibrillation (Irregular heartbeat)
HIV/Aids
BPH (benign enlarged prostate)
Hypercholesterolemia (high cholesterol)
Bone Marrow Transplantation
Hyperthyroidism
Breast Cancer
Hypothyroidism
Colon Cancer
Leukemia
COPD
Prostate Cancer
Coronary Artery Disease
Radiation Treatment
Depression
Seizures
Diabetes
Stroke
End Stage Renal Disease
GERD
Other _____

SURGICAL HISTORY (list all surgeries)

_____

_____

SKIN DISEASE HISTORY

Acne
Flaky or itchy scalp
Actinic Keratosis
Skin cancer: Basal Cell Carcinoma _____; Squamous Cell Carcinoma _____; Melanoma____
Blistering Sunburn
Precancerous Moles
Dry Skin
Psoriasis
Eczema
Other _____
Do you wear Sunscreen? If yes, what SPF?_____ Do you tan in tanning salon? Y__N__

FAMILY HISTORY OF MELANOMA _Yes or ___No

If yes, which relative __Mother __Father __Sister __Brother __Daughter __Son
__Uncle __Aunt __Nephew __Niece __Grandmother __Grandfather

MEDICATIONS (Please list- if you have a list with you, document, see list, and give to nurse in exam room)

_____
_____
_____

ALLERGIES TO MEDICATIONS? YES_____N0_____
If "Yes", what medications

_____

FEMALES ONLY Last menstrual period (LMP)_____ Menopausal __Yes or __No

SMOKING HISTORY

Current every day smoker / Former smoker /Nonsmoker (Circle one)

Please mark Yes or No if you have any of the following
Pacemaker __YES __NO
Defibrillator __YES __NO
Premedication prior to procedure __YES __NO
Allergy to adhesive __YES __NO
Blood thinners __YES __NO
Pregnancy or planning a pregnancy __YES __NO __N/A
Allergy to lidocaine __YES __NO
Allergy to Latex __YES __NO
Rapid heartbeat with epinephrine __YES __NO
Have you ever had dental anesthesia (Novocain)? __YES __NO
Problems with bleeding __YES __NO
Artificial joints within past two years __YES __NO
Artificial heart valve __YES __NO
Allergy to topical antibiotic ointment __YES __NO
Are you your own Power of Attorney (POA)? __ YES __ NO

REASON FOR YOUR VISIT TODAY

1. _____
2. _____

Primary Care Physician (PCP): Name_____
Primary Care Physician (PCP): Phone Number_____

CHECKLIST

Patient:_____ **Date:**___/___/___

1.	Heart Murmur/ Mitrovalve prolapsed	Yes	No
2.	Pace Maker/ Defibrillator	Yes	No
3.	Stents	Yes	No
4.	Organ Transplant	Yes	No
5.	Orthopedic (Pins, screws, rods) Any & All Implants (Breast etc...)	Yes	No
6.	Aspirin, Plavix or Vitamin E	Yes	No
7.	Cholesterol Medication	Yes	No
8.	Allergy to PCN (Penicillin)	Yes	No
9.	Allergy to Epi (Epinephrine)	Yes	No

Any other known Drug Allergies to Medications:_____

_____

_____

Premedication Name:_____

_____

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for, Renata Flaks, DNP to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations {TPO}. *(Renata Flaks, DNP's Notice of Privacy Practices provides a more complete description of such uses and disclosures)*

I have the right to review the Notice of Privacy Practices prior to signing this consent. The practice reserves the right to revise its Notice of Privacy Practices at Renata Flaks, DNP's anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Renata Flaks, DNP.

Privacy Officer at

Renata Flaks, DNP
707 Main Street
Toms River, NJ
08753

With this consent, Renata Flaks, DNP may call my home, cell or other phone number listed on my chart 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 anything pertaining to my medical care, including laboratory test results among others.

With this consent, Renata Flaks, DNP may mail to my home or other alternative locations listed on my chart any item 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.

With this consent, Renata Flaks, DNP may e-mail me any items assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Renata Flaks, DNP 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 Renata Flaks, DNP's use and disclosure of my PHI to carry out my 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, Renata Flaks, DNP may decline to provide treatment to me.

Signature of Patient or Legal Guardian _____

Print Name of Patient or Legal Guardian _____

Date _____/_____/_____

Quality Dermatology, LLC

Renata Flaks, DNP
Doctor of Nursing Practice
707 Main Street
Toms River, NJ 08753
(732) 244-2666

Patient or POA:_____

Please be advised, although your insurance company has authorized services, this is not a guarantee of payment. If your insurance company denies those services, you will be responsible for payment. (Please initial)_____

I have been advised that if Quality Dermatology does not accept my secondary insurance I will be responsible for any remaining balance after my primary insurance. (Please initial)_____

It is my responsibility to obtain a referral if it is required by my insurance. If I fail to provide a valid referral at the time of service and my insurance denies my bills for lacking referral/authorization, I will be responsible for payment in full to Quality Dermatology. (Please initial)_____

_____
Patient or POA Signature

_____
Date