ADVANCED DERMATOLOGY
MOHS & LASER SURGERY CENTER, P.A.

Advanced Dermatology,
Mohs and Laser Surgery Center, P.A.
240 East Grove Street
Westfield, New Jersey 07090-1687
Phone: 908.232.6446
Fax: 908.232.6447
advanceddermnj.com

Appointment Date:_____

Time:_____

Doctor: _____

Physician Assistant:_____

Dear Patient,
Thank you for scheduling an appointment with our practice! Please read the information below.

Our Patient Portal

We invite you to register for our patient portal. https://advanceddermnj.ema.md.

Please use this portal to update your medications and health history prior to your appointment. **This portal is for your health history only.** You will still need to fill out and print the **Registration form**, the **HIPAA form**, and the **Designation of Relatives form** found in this packet**.** You can also access your patient record in the future. If you provided us with your email address, you should have received an invitation to register. If you have not received 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 of your 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 TO US.**

On the day of your appointment

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.

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

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

We look forward to seeing you!

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Insurance Form

PLEASE PRESENT THE RECEPTIONIST WITH ALL OF YOUR INSURANCE CARDS

First Name:_____ **M.I.**_____ **Last Name:**_____
Address:_____

_____

City:_____ **State:**_____ **Zip:**_____

Date of Birth:_____/_____/_____

Home #: (____) _____ - _____ **Email Address:** _____
Cell #: (____) _____ - _____ **Work #:** (____) _____ - _____

Gender: M/F/T/Other **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 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: _____ M.I. _____
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: _____ M.I _____
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,
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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
- ☐ allergy to latex
- ☐ allergy to topical antibiotic
- ☐ pacemaker
- ☐ pregnancy/planning pregnancy
- ☐ heart valve/joint replacement
- ☐ pre-medicate prior to procedure
- ☐ blood thinner
- ☐ Defibrillator

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 ever 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 so, 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
- ☐ Grandma
- ☐ Grandpa
- ☐ 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)

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day
- ☐ Current everyday smoker
- ☐ Occasional smoker
- ☐ Former smoker
- ☐ Never 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
- ☐ _____ **Number**

Started Smoking:
mm/dd/yyyy _____
Number of Packs per Day _____

Quit Smoking:
mm/dd/yyyy _____
Total Years Smoking _____

Family History

Please include only first-degree relatives: indicate relation on line.

- ☐ Skin Cancer_____
- ☐ Atypical Moles_____
- ☐ Pre-cancers_____
- ☐ Keloid Scars_____
- ☐ Atopy (i.e. allergies, asthma, hay fever, eczema)_____
- ☐ Skin Disease (Specify)_____
- ☐ Others_____

_____ _____

Health History Form

Review of Systems

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

Immunizations/Vaccines

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, please name them:**_____ **Their 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: _____ Date: _____

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HIPAA AND PRIVACY

I acknowledge having been offered a copy of the patient's Notice of Privacy Practices.

_____ _____ _____

Signature **Date** **Print 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.

PRINT NAME:_____ **DATE:**_____

PATIENT SIGNATURE:_____

CREDIT CARD COLLECTION POLICY (OPTIONAL)

Dear Patient,
In an effort to streamline patient billing and to avoid collection issues, we offer patients the option of leaving a credit card on file with us. 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.

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

PRINT NAME: _____ **DATE:**_____

PATIENT SIGNATURE:_____

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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 Name **Date**

Patient Signature