

Goldin Skin Dermatology

PATIENT INFORMATION SHEET

Today's Date: _____

Name: Last _____ First _____ MI _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home: () _____ Work: () _____

Cell Phone: _____

E-Mail _____

Sex: M F Marital Status: S M D W

Race: _____ Ethnicity: _____ (This info may help with diagnosis/treatment.)

Age: _____ Date of Birth: _____ SSN: _____

Employer (If Applicable): _____

Address: _____

Phone: _____

Responsible Party (Complete if different from above or if the insurance is under another person's name):

Name: Last _____ First _____ MI _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home: () _____ Work: () _____

Date of Birth: _____ SSN: _____ Relationship to Pt: _____

HOW DID YOU HEAR ABOUT US? *Circle your response(s):*

Patient Physician Insurance Internet Hospital Return Patient Other: _____

Referral Name: _____ Relationship: _____

MEDICAL INFORMATION

PHYSICIANS:

PRIMARY: _____ Address: _____

OTHER: _____ Address: _____

PHARMACY: Name: _____ Location: _____

MEDICAL CONDITIONS: *Please list:*

SKIN CANCERS: Basal Cell Carcinoma Squamous Cell Carcinoma Melanoma

Other Cancers: _____

Other Illnesses: _____

OPERATIONS: *Please list:*

CURRENT MEDICATIONS: *(Include Vitamins, Herbs, and Supplements) Please list:*

() I do not take any medications.

FEMALE PATIENTS: Periods: Regular Irregular Pre-periods Menopause
Infertility Problem? None Present Past

FAMILY HISTORY: *Circle conditions below which apply to your family.*

Acne Psoriasis Hives Eczema Hayfever Asthma

Skin Cancer: Basal Cell Carcinoma Squamous Cell Carcinoma Melanoma

ALLERGIES TO MEDICATIONS: *Please list:*

() I have no known allergies to medications

SOCIAL HISTORY:

Occupation: _____

Who lives with you at home? _____

Do you go to tanning salons? Yes No (If yes, we recommend that you stop.)

Do you smoke? Yes No (If yes, we recommend that you stop.)

IN CASE OF EMERGENCY NOTIFY:

Name: _____ Address: _____

_____ Relationship: _____

_____ Phone: _____

CURRENT PROBLEMS (ROS): *Circle conditions that apply to you:*

Constitutional: Fever Weight Loss Night Sweats Fatigue

Skin: Rashes Itching Hair Change Nail Change

Eyes: Loss of Vision Distorted Vision Eye Pain

ENT: Loss of Hearing Ringing Dizziness Sinus Congestion Runny Nose

Nosebleeds Hoarseness Dryness

Cardiovascular: Chest Pain Palpitations Swelling of Legs

Pulmonary: Cough Shortness of Breath Wheezing

Endocrine: Heat or Cold Intolerance Excessive Thirst or Hunger

Gastrointestinal: Swallowing Difficulty Heartburn Diarrhea Constipation Vomiting
Incontinence

Genitourinary: Urinary Frequency Urinary Pain Blood in Urine Incontinence

Males: Penile Discharge Lumps on Testicles

Females: Breast Lumps/Discharge Vaginal Bleeding/Discharge

Musculoskeletal: Joint Pain Muscle Pain/Cramps

Neurological: Headaches Numbness/Tingling Weakness Blackouts Slurred Speech

Psychiatric: Anxiety Depression Mania

Hematological: Easy Bruising/Bleeding Anemia

Immunological: Frequent Infections Swollen Lymph Glands

Other Problems: _____

() I have none of these problems listed above.

WHAT IS/ARE THE MAIN REASON(S) YOU CAME TODAY?

1. _____

2. _____

3. _____

OFFICE POLICY, RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS

I certify that the above information is complete and accurate.

I authorize Goldin Skin Dermatology and Dermatologic Surgery to release any information required to process insurance claims. I authorize payment directly to Goldin Skin Dermatology and Dermatologic Surgery for all the surgical, medical and/or laboratory benefits. I authorize automatic cross-over from Medicare to my secondary insurance.

I understand that:

- I am financially responsible for any uncovered services, which includes reasonable costs and fees of any collection activities for unpaid amounts.
- **24 hour notice** is required if I am unable to keep my scheduled appointment. I will be billed **\$25.00 for every 15 minutes** scheduled that is missed or not cancelled before 24 hours. This includes appointments not kept due to not having a valid HMO referral.
- All **surgical appointments** require **72 hours notice** of cancellation. I will be billed at the rate of **\$200.00 per hour** of time scheduled.
- I will be billed an **additional \$10/month** if I do not pay my **copay** on the date I am seen.
- A fee determined by state law will be charged if I request a copy of my medical records.

This office cannot schedule **HMO appointments** without a valid referral from the primary care physician and/or the HMO. I agree to be **financially responsible** for charges incurred if I come **without a valid HMO referral**. It is my (the patient's) responsibility to obtain the HMO referral

Signature of Insured or Authorized Person (You must be over 18 years old to sign)

Relationship to Patient

BE SURE TO ASK ABOUT:

- **RESTYLANE/PERLANE** injections to fill wrinkles
- **PDT LIGHT TREATMENTS** for acne, warts, skin cancers, pre-cancers and facial rejuvenation
- **BOTOX INJECTIONS** for frown lines and crows feet.
- **CHEMICAL PEELS** to refresh complexions
- **SCLEROTHERAPY** for unsightly leg veins