ORANGE DERMATOLOGY ASSOCIATES, P.C.

(Side 1)

MEDICAL HISTORY

Name:________________________ DOB:__________ Today's Date:___/___/___

Current Problem:

1. Reason for visit *(circle)* (rash, growths, skin cancer check, other ______________________)
2. How long have you had this problem?______________________

	YES	NO
3. Have you had this problem before? If yes, when?__________What did you do for it?______________	☐	☐
4. Is this problem worse during certain seasons or with temperature changes? If yes, when? *(circle)* Fall, Winter, Spring, Summer, hot, cold	☐	☐
5. Where is your problem located? *(circle)* Scalp, ears, eyelids, face, neck, chest, back, arms, underarms, hands, fingers, stomach, groin, thighs, legs, feet, toes, hair, nails, mouth		
6. Does the problem *(circle)* itch, burn, hurt, bleed, ooze, other?______________	☐	☐
7. Has a doctor given you anything in the past to put on or take by mouth for your present skin problem? If yes, please list:______________	☐	☐
8. Have you put anything else on the skin yourself? If yes, please list:______________	☐	☐
9. Do you have any growths which *(circle)* change color, grow, bleed, hurt, itch? If yes, where?______________	☐	☐

Medications:

10. Are you allergic to any oral or topical medications? If yes, what?______________	☐	☐
11. Have you ever had any reaction to dental anesthesia?	☐	☐
12. List all medications you are currently taking by mouth or putting on your skin (including prescriptions, over-the-counter, vitamins and herbals):______________		

Skin:

	YES	NO
13. Have you had skin cancer? Type______________	☐	☐
14. Have you had *(circle)* psoriasis, eczema, other skin condition? Please list:______________	☐	☐
15. Have you had *(circle)* asthma, hay fever?	☐	☐
16. Do you have problems with healing? If yes, what kind?______________	☐	☐
17. Do you develop keloids (thick or elevated scars) after surgery?	☐	☐
18. Do you bleed easily?	☐	☐
19. Is there a family history of *(circle)* skin cancer, psoriasis, eczema?	☐	☐
20. Is there a family history of *(circle)* asthma, hay fever?	☐	☐
21. Any other family skin condition? If yes, please list:______________	☐	☐

Social History:

	YES	NO
22. Do you drink alcohol regularly?	☐	☐
23. Do you smoke cigarettes regularly?	☐	☐
24. Have you had or been exposed to HIV (AIDS)?	☐	☐

25. What is your Occupation?______________

26. Hobbies?______________

(PLEASE COMPLETE BOTH SIDES)

Systemic:

27. Do you have now, or have you ever had diseases or conditions of: ***(Please check Yes or No)***

	YES	NO		YES	NO
High Blood Pressure	☐	☐	Thyroid	☐	☐
Heart Attack	☐	☐	Kidney	☐	☐
Irregular Heartbeat	☐	☐	Gastrointestinal:	☐	☐
Phlebitis (Inflammation of vein)	☐	☐	*(circle)* heartburn, acid reflux, ulcers		
Blood clots	☐	☐	Arthritis/Joint/Muscle Disease	☐	☐
Pacemaker	☐	☐	Artificial joints	☐	☐
Angina	☐	☐	Convulsions, Epilepsy or Seizures	☐	☐
Heart Surgery	☐	☐	Immune Problems________________	☐	☐
Diabetes	☐	☐	________________		
Strokes	☐	☐	Hepatitis, If yes, what type?________	☐	☐
			Cancer, Type? ________________	☐	☐

28. Other diseases or conditions:____

____

29. List surgical procedures you have had in the last 6 months:________________________________

____

	YES	NO
30. **Do you need to take antibiotics by mouth before surgical or dental procedures?**	☐	☐
31. a) **Are you pregnant?**	☐	☐
b) **Are you breastfeeding?**	☐	☐
c) Are you taking hormones or birth control pills? If yes, please list________________	☐	☐
32. Were you referred by *(circle)* physician, friend, relative, other? Name:________________	☐	☐

ARE YOU INTERESTED IN GETTING MORE INFORMATION ABOUT COSMETIC PROCEDURES?

	YES	NO
a) LASER hair removal?	☐	☐
b) LASER removal of facial redness and spider veins?	☐	☐
c) Microdermabrasion?	☐	☐
d) Sclerotherapy for leg veins?	☐	☐
e) Restylane or Collagen injections	☐	☐
f) Botox Cosmetic	☐	☐

Completed by: ☐ Patient ________________________ Date ___/___/___
☐ Medical Assistant ________ Signed by Patient

________________________ Date ___/___/___
Reviewed by

(HAVE YOU COMPLETED BOTH SIDES?)

ORANGE DERMATOLOGY ASSOCIATES, P.C.

PATIENT INFORMATION

(Please Print) Today's Date___/___/___

Name____ SS#______________
Last *First* *M.I.*

Mailing Address____
City *State* *Zip*

Home Phone______________ Work Phone______________ Cell Phone______________
Area Code *Area Code* *Area Code*

Date of Birth___/___/___ Age_____ Sex_____ Marital Status_______ Occupation______________

POLICY HOLDER /RESPONSIBLE PARTY *(if different from patient)*

Name____
Last *First* *M.I.*

Address____
City *State* *Zip*

Home Phone______________ Work Phone______________ SS#______________
Area Code *Area Code*

Date of Birth___/___/___ Sex_____ Marital Status_______ Occupation______________

INSURANCE INFORMATION *(Please present insurance card at time of check in.)*

Primary Insurance Name______________________
Ins. Address______________________
Name of Insured______________________
Insured's ID#______________________
Group #______________________
Employer Name______________________
Employer Address______________________
Employer Phone______________________
Area Code
Relationship of patient to the Insured______________

Secondary Insurance Name______________________
Ins. Address______________________
Name of Insured______________________
Insured's ID#______________________
Group#______________________
Employer Name______________________
Employer Address______________________
Employer Phone______________________
Area Code
Relationship of patient to the Insured______________

Other family members that are patients______________________________ Phone______________
In case of Emergency, who should be notified?__________________________ Phone______________

WE RESPECT YOUR PRIVACY (The HIPAA Policy is posted in the office)

All medical records of Orange Dermatology Associates, P.C. are strictly confidential. You are entitled to access your own medical records.

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims and prescriptions. I also authorize payment of medical benefits to Orange Dermatology Associates, P.C.

I understand and agree that, regardless of my insurance status, I am responsible for the balance of my account for any professional services rendered, including any unmet deductibles, co-payments and non-covered services. If my account is turned over to a collection agency or if I fail to keep a scheduled appointment, a service charge will be added.

To insure patient confidentiality, our office policy is to give test results to the patient only. If we call your home and another member of your household answers the telephone, may we leave results? Yes ☐ No ☐
May we leave personal medical information on your answering machine at home? Yes ☐ No ☐

I acknowledge reading this entire page.

Patient or Responsible Party (if minor) Signature______________________________ Date___/___/___

Office use only ☐ Copy of insurance card (both sides) attached. Updated By:______________

Orange Dermatology Associates, P.C.

TO ALL MEDICARE PATIENTS

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Orange Dermatology Associates, P.C. which accepts assignment.

____ ______/______/______
Signature as it appears on Medicare Card Date

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

____ ______/______/______
Signature as it appears on Medigap Card Date

1. THE FEES APPROVED ARE SET BY MEDICARE, NOT ORANGE DERMATOLOGY.
2. MEDICARE WILL NOT PAY THE ENTIRE AMOUNT, BUT **WILL USUALLY PAY 80% OF THE APPROVED CHARGE.**
3. **I AM RESPONSIBLE FOR THE BALANCE, WHICH IS USUALLY 20% OF THE APPROVED CHARGE.**
4. **EVERY YEAR** THERE IS A **MEDICAL DEDUCTIBLE** WHICH I MUST PAY. AT THE PRESENT TIME, THE DEDUCTIBLE IS **$100.00.**
5. CERTAIN PROCEDURES, SUCH AS REMOVAL OF GROWTHS FOR COSMETIC REASONS, ARE NOT COVERED BY MEDICARE. THEREFORE, I AM RESPONSIBLE FOR PAYMENT OF THESE PROCEDURES **AT THE TIME OF SERVICE.**
6. ALL MEDICARE CLAIMS WILL BE FILED ELECTRONICALLY, AND I GIVE MY WRITTEN PERMISSION TO DO SO.

I HAVE READ THE ABOVE AND UNDERSTAND AND AGREE TO COMPLY WITH THE ABOVE.

NAME (PLEASE PRINT) ____

____ ______/______/______
Signature as it appears on Medicare Card Date

ORANGE DERMATOLOGY ASSOCIATES, P.C.
JOSEPH G. TUCHMAN, M.D.
STEVEN WOLINSKY, M.D.
SAMMY A. HUTMAN, M.D.
MICHAEL B. BRODIN, M.D.
DIPLOMATES, AMERICAN BOARD OF DERMATOLOGY

503 ROUTE 208
MONROE, NEW YORK 10950
TELEPHONE (845) 783-2920
FAX (845) 783-2916

8 FORESTER AVENUE
WARWICK, NEW YORK 10990
TELEPHONE (845) 986-6999
FAX (845) 986-4820

INFORMED CONSENT FOR PROCEDURES

My signature on this form authorizes the Doctors and Physician Assistants of Orange Dermatology Associates, P.C. to perform procedures on me that they feel are necessary for my well being, including, but not limited to injections, freezing with liquid nitrogen (cryosurgery), electrodesiccation, biopsy and excisions. Before any procedure is done, I will be informed, to my satisfaction why the procedure is necessary. I will be told what the procedure involves and what risk there is to my health, if any, if the condition were to remain undiagnosed or untreated.

I understand the risk inherent to the performance of any surgical procedure such as loss of blood, infection, reaction to anesthesia and the formation of thick or otherwise objectionable scars, and I realize that such, or any, natural complications may result from the surgical procedure.

I give my permission to have any tissue(s) removed during the procedure be sent for histologic examination by a pathologist.

____

Signature of patient or patient's legal guardian — Date
Signifying informed consent

____

Witness — Date