

SOUTH NASSAU DERMATOLOGY, P.C.

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Name _____ **Date** _____

Address _____ **Phone** _____ **S/S#** _____

Cell Phone _____ **Work Phone** _____

DOB _____ **1st Insurance** _____ **2nd Insurance** _____

Name of Ins. Co. _____ **Name of Ins. Co.** _____

Subscriber _____ **Subscriber** _____

Relationship _____ **Relationship** _____

ID # _____ **ID #** _____

INITIAL VISIT QUESTIONNAIRE

Please Always Remember To Tell Us Of New Developments In Your Medical Background.

Please circle the appropriate answer:

Have you been treated for, or do you have problems with any of the following body systems?

- | | | | |
|----------------|---|-----|----|
| | neurologic, immunologic or hematologic | yes | no |
| | eyes, ears, nose & throat | yes | no |
| | GI: duodenal, peptic ulcers, colitis, or intestinal disease | yes | no |
| | tuberculosis or lung disease | yes | no |
| | heart disease or pacemaker | yes | no |
| | high blood pressure | yes | no |
| | kidney disease | yes | no |
| | liver or gall bladder disease | yes | no |
| Social History | emotional disorders or psychiatric problems | yes | no |
| | urinary or bladder problems or infections | yes | no |
| | venereal diseases | yes | no |
| | diabetes, or thyroid or other hormonal problem | yes | no |
| | have you ever had cancer | yes | no |

Have you ever had radiation treatments, or Grenz ray treatments, x-ray treatments? yes no

Please list areas treated and year of treatment. _____

- Do you use sun screen? _____ always _____ sometimes _____ never
- Do you smoke? _____ Yes _____ No
- Do you drink? - How much? _____
- What soap do you use? _____
- What moisturizer do you use? _____

Have you had a recent operation or accident? yes ___ no ___ what? _____

Have you or any member of your blood relatives had problems with any of the following:

(please list relationship to person with the problem.) _____

				Patient	Family Member
Asthma	yes	no	_____	_____	_____
Hay Fever	yes	no	_____	_____	_____
Hives	yes	no	_____	_____	_____

(Over)

			<u>Patient</u>	<u>Family Member</u>
Eczema	yes	no	_____	_____
Diabetes	yes	no	_____	_____
Psoriasis	yes	no	_____	_____
Skin Cancer	yes	no	_____	_____

Please tell us if you have any new conditions while you are under our care. If you are pregnant please check with us regarding your treatment.

If you do not desire a complete skin examination please initial here: _____

- Have you ever had
- | | | |
|---|-----|----|
| difficulty with the healing of wounds | yes | no |
| excessive bleeding when cut | yes | no |
| overgrown scars or keloids | yes | no |
| allergic reactions to local anesthetics | yes | no |
- Are you allergic to any medications or over the counter remedies?
(If yes, please list.)
- | | | |
|--|-----|----|
| | yes | no |
|--|-----|----|
- Are you now taking any medicines or over the counter remedies?
(If yes, please list.)
- | | | |
|--|-----|----|
| | yes | no |
|--|-----|----|
- Are you undergoing treatment for any medical condition now.
- | | | |
|--|-----|----|
| | yes | no |
|--|-----|----|
- Have you had a previous skin disease or been treated by a Dermatologist?
(If yes, describe.)
- | | | |
|--|-----|----|
| | yes | no |
|--|-----|----|
- Do you have a heart valve problem or an artificial joint that requires premedication.
- | | | |
|--|-----|----|
| | yes | no |
|--|-----|----|

Prior hospitalization and surgery. Please give approximate date.

For women only:

- Have you had vaginal yeast infections?
- Are you pregnant?
- Are you planning a pregnancy?
- (Please inform the doctor if you do plan on becoming / or do become pregnant during your treatment period.)

When was your last period.

GUARANTEE OF PAYMENT I/We do hereby and agree to pay to South Nassau Dermatology, P.C. the full and entire amount of any and all bills rendered for above named patient for services rendered.

If I am a managed care or HMO patient I assume responsibility for any services that are not a part of my referral, and will pay for those services at the time they are provided.

_____ Date _____ Signature

For Medicare Patients: _____