PATIENT INTAKE FORM

Patient Name: ______________________________ Date: __________________

Please answer the following questions so that our practice is compliant.

Thank You

1) Do you have any of the following?
   - Heart Failure
   - Coronary Artery Disease (CAD)
   - Chronic Obstructive Pulmonary Disease (COPD)
   - Diabetes

2) Did you receive the flu vaccine? YES NO If yes, was it for the Current or Last season

3) Have you ever received the pneumonia vaccine? YES NO

4) Do you have a history of Melanoma? YES NO

5) Do you have a history of Shingles? YES NO

6) Have you ever received the Shingles vaccine? YES NO

7) Primary Care Physician (PCP): ____

   Month and Year of your last Primary Care Physician visit: ___________________

PATIENT REGISTRATION FORM

Date: ______________

Patient's Name: ______________________________ Sex: ________
Address: ______________________________
City: ______________________ State: __________ Zip: ________
Home Phone: ______________________ Cell Phone: ______________________
Social Security #: ________________ Birthdate: ______________ Age: ________
Marital Status Single ______ Married ________ Divorced ________ Widowed ______

**Email address: ______________________________

EMPLOYMENT INFORMATION

Employer: ______________________ Occupation: ______________________
Employer Address: ______________________________
City: ______________________ State: ____________ Zip: ________

INSURANCE INFORMATION

Primary

Insurance Company Name: ______________________________
Name of Subscriber: ______________________________
Relationship to patient: Self ______ Spouse ______ Parent ______ Other ______
Date of Birth: __________ ID#: ________________ Group #: ____________
Employer Name: ______________________ Address: ______________________
______________________________ Employer Phone: ______________

Secondary

Insurance Company Name: ______________________________
Name of Subscriber: ______________________________
Relationship to patient: Self ______ Spouse ______ Parent ______ Other ______
Date of Birth: __________ ID#: ________________ Group #: ____________
Employer Name: ______________________ Address: ______________________
______________________________ Employer Phone: ______________

Name of Primary Care Physician: ______________________ Phone#: ____________
Address: ______________________________
Name of Referring Physician: ______________________ Phone#: ____________
Address: ______________________________

I hereby authorize release of any information necessary for processing of my insurance.
Signature: ______________________________

I understand that I am financially responsible to all charges, whether or not paid by insurance.
Signature: ______________________________

Date: ______________________

Patient Name: ______________________________ **Date Of Birth:** ______________

Primary Care Physician: ______________________ **Marital Status:** Single Married Divorced Widowed

Referring Physician: _________________________ **Pt. Phone: Home** _______________ **Cell** ___________

Past Medical History: (please **circle** all that apply)

Anxiety	Diabetes	Lung Cancer
Arthritis	End Stage Renal Disease	Lymphoma
Asthma	GERD	Pacemaker
Atrial Fibrillation	Glaucoma	Prostate Cancer
Bone Marrow Transplantation	Hearing Loss	Radiation Treatment
BPH	Hepatitis	Seizures
Breast Cancer	High Blood Pressure	Stroke
Colon Cancer	High Cholesterol	Thyroid Problems (Hyper or Hypo)
COPD	HIV/AIDS	Transplantation of ______________
Coronary Artery Disease	Leukemia	Other: ____________________
Depression		NONE

Past Surgical History and Hospitalizations: (please list all)

____

____

Skin Disease History: (please **circle** all that apply)

Acne	Dry Skin	Poison Ivy	
Actinic Keratosis	Eczema	Precancerous Moles	
	Flaking or Itchy Scalp	Psoriasis	Rosacea
Basal Cell Skin Cancer	Hay Fever/Allergies	Shingles (Herpes Zoster)	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	NONE	

Other ____

Do you wear Sunscreen? Yes No If yes, what SPF? __________________

Do you tan in a tanning salon? Yes No

Medications (please list all current medications with dosages and frequency) **If you carry a list we will gladly make a copy.**

____

____

____

Do you have allergies to medications? YES NO If yes, please list: _________________________

____

Social History: (please **circle** all that apply)

Cigarette Smoking:

Never Smoked

Quit: Former Smoker

Smoke less than Daily

Smoke Daily

Preferred Language:

English

Spanish

Other: ______________________

Alcohol Intake:

None

Less than one drink per day

1-2 Drinks per day

3 or more drinks per day

***How many days have you had 4+ drinks in the last year?** ________________

Race:

White

Black/African American

Asian

Other: ______________________

Ethnic Group:

Hispanic/Latino

Non-Hispanic/Latino

*****What is the reason for your visit today?** ____

****Do you give permission for us to import your list of medications from your pharmacy? YES NO**

Alerts: (please **circle** all that apply)

Allergy to Adhesive

Allergy to Lidocaine

Allergy to topical antibiotics

Artificial heart valve

Blood thinners

Defibrillator

MRSA

Pacemaker

Require antibiotics prior to surgical procedure

Rapid heartbeat with epinephrine

Are you pregnant or currently trying to get pregnant?

****Do you have an Advanced Care Directive/Plan? Yes _____ No _____**

If so, who is your Surrogate Decision Maker? ____

Family History (please **circle** all that apply)

Melanoma	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather	Cousin
Diabetes	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather	Cousin

RITA WEINSTEIN, M.D.
JEREMY ROTHFLEISCH, M.D., P.A.
Dermatology, Cosmetic Dermatology, Laser & Cosmetic Surgery
603 Cranbury Road
East Brunswick, NJ 08816

Assignment of Medical Insurance Benefits

Thank you for choosing us for your dermatological needs. We will work to help you with your insurance claims, but would like you to understand our office policy regarding insurance assignment.

Payment is due at the time of service, unless we accept assignment with your primary insurance company.

Please be aware that it is your responsibility to:

1. Provide complete up-to-date information on your medical insurance coverage.
2. Present a valid insurance card.
3. Pay any co-payment, and/or any non-covered services at the time of service.
4. Present a valid referral or authorization for services (if required by your plan). Keep in mind that a referral from a primary care physician does not guarantee that the service will be covered (i.e. paid for) by your insurer. In which case, you will be responsible for all charges incurred.

If we do not participate with your primary, but we do participate with your secondary insurance:

1. Full Payment is expected at time of service. We accept Visa, MasterCard, American Express, Discover, Personal Check and Cash.
2. We will give you a bill to submit to your primary insurance carrier.
3. If payment is inadvertently made to our office, we will issue you a reimbursement check in a timely fashion.

Your signature below indicates:

1. You understand and accept our policy of assignment of insurance benefits.
2. You attest to the accuracy and completeness of your medical insurance coverage.
3. You authorize this office to release medical information necessary to process your claims and appeals.
4. You authorize payment of medical benefits to Rita Weinstein, M.D. and/or Dr. Jeremy Rothfleisch, M.D.

______________________________ ________________
Signature of Patient or Responsible Party Date

RITA WEINSTEIN, M.D.
JEREMY ROTHFLEISCH, M.D., P.A.
Dermatology, Cosmetic Dermatology, & Laser Surgery
603 Cranbury Road
East Brunswick, NJ 08816
(732) 545-5366

Date: ___________________

I give permission for Dr. Weinstein/Dr. Rothfleisch and their staff to share my medical information with the following family member(s) or special friends:

___________________________________ ____________________
Print Name & Relationship to patient **Phone #**

___________________________________ ____________________
Print Name & Relationship to patient **Phone #**

May we leave your personal information on an answering machine Yes ___ No ___
Home Cell Both

____
Patient Signature

*****DO YOU WANT THE OPTION TO VIEW YOUR MEDICAL RECORD ONLINE?**

YES ______________ **NO** ______________

Email address: ____

PHARMACY INFORMATION

Pharmacy name and/or mail order pharmacy_____________________________________

Address ____

Phone ____

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If you have Medicare, please sign.

If Medicare sends your claims directly to your secondary insurance, please sign the bottom line also.

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

Medicare:

I authorize any holder of medical or other information about me be released to the Social Security Administration and Health Care Financing Administration 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 if medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment or benefits apply.

______________________________ _______________
Signature as it appears on Medicare Card Date

Medigap:

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 be 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

Assignment of Benefits-Medicare