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DERMATOLOGIC SURGEONS



[www.dermcare.us](http://www.dermcare.us)

Suzanne K. Freitag, M.D.  
OCULOPLASTIC SURGEON

Loreen A. Ali, M.D.  
PLASTIC & RECONSTRUCTIVE  
SURGEON

Michael S. Krathen, M.D.  
Steven I. Kornbleuth, M.D.  
GENERAL DERMATOLOGISTS

## Welcome or Welcome Back to our Practice!

Dear Patient:

Dermcare Physicians & Surgeons are dedicated to providing our patients with the best care and customer service. Enclosed please find patient information and release forms. Before your visit, please carefully read and complete these forms and bring them with you to your scheduled appointment. Please arrive 10 minutes prior to your appointment.

**The packet includes:**

Patient Gateway (Portal) Sign up form  
Patient Registration & HIPAA Privacy Form  
Medical/Surgical History Form (if applicable)  
Directions to our office

**Appointment Tips:**

Write down and bring with you to your visit any questions you want to ask  
Bring a list of your medications & over the counter medications  
Please feel free to bring a family member or friend for support

We participate with many insurance companies; however, it is your responsibility to check with your insurance company to ensure that we participate and whether or not a referral is required for your visit.

If for any reason, you are unable to make it to the scheduled appointment, it is imperative that you call us 24 hours in advance to cancel or reschedule so that we can offer your appointment to another patient. New patient "NO SHOW" visits will not be rescheduled.

Please visit our website [www.dermcare.us](http://www.dermcare.us) for more information about our practice and a copy of all of our forms.

If you would like to correspond with our office via email regarding your care and treatment, please sign up to our Patient Gateway, [www.patientgateway.org](http://www.patientgateway.org). We look forward to seeing you!

### *The Physicians and Staff of Dermcare Physicians and Surgeons*

22 Mill Street, Suite 304  
Arlington, MA 02476  
P 781.641.4900 F 781.641.4904

33 Village Square  
Chelmsford, MA 01824  
P 978.244.0060 F 978.244.2522

154 East Central Street, 3rd floor  
Natick, MA 01760  
P 781.431.0060 F 781.431.0062

9 Hope Avenue, Suite 151  
Waltham, MA 02453  
P 781.810.9998 F 781.431.0062

*Members of:*

*Newton Wellesley Physician Hospital Organization • Mount Auburn Cambridge Independent Practice Association • Beth Israel Deaconess Care Organization  
MetroWest Accountable Healthcare Organization • Emerson Hospital Independent Physician Association • Lowell General Physician Hospital Organization • Steward Healthcare*

## GENERAL PATIENT INFORMATION

Patient Name _____		Preferred name: _____	
Date of Birth _____	SSN _____	Marital Status S M W D	
Address _____		City _____	State _____ Zip _____
Check preferred contact method. <input type="checkbox"/> Home Phone _____		<input type="checkbox"/> Cell Phone _____	
Email Address: _____ (Email address to be used to communicate health events, practice news, cosmetic specials and events only generated by the practice administrator. Email addresses are kept securely within our practice management system only.)			
Primary Care Physician _____		Town _____	Phone _____
Specialist physician who referred you _____		Town _____	Phone _____
Your Cardiologist (if seeing one) _____		Town _____	Phone _____
Race: <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American Language Spoken: _____			
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined to state <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Declined to state			
Employment Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> Student Occupation _____			

### MEDICAL EMERGENCY CONTACT INFORMATION

Contact Name _____	Relationship _____
Home Phone _____	Cell Phone _____

### AUTHORIZATION TO BILL INSURANCE

I hereby authorize and request my insurance company to pay Dermcare directly the amount due on my claim for services provided to my dependent or me. I also agree that should the amount be insufficient to cover the entire medical and/or surgical expense, I will be responsible for the payment of the difference and if the service provided is considered a non-covered service; I will be responsible for payment of that service.

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Center for Medicare and Medicaid Services or its intermediaries any information needed for this or related claim. I permit a copy of the authorization to be used in place of the original and request payment or medical services to be made to the party who accepts assignment. I certify that this information is true and correct to the best of my knowledge.

**Responsible for the Balance** – Although you may have health coverage through another person, all billing/payment information will always be sent directly to you and will be your responsibility.  I have reviewed a copy of the office financial policy which is available at [www.dermcare.us](http://www.dermcare.us).

Patient Signature _____	Print Name _____	Date _____
Guardian Signature _____	Print Name _____	Date _____

### HIPAA PRIVACY INFORMATION - Acknowledgement of Receipt of Notice of Privacy Practices

Privacy notice of the privacy practices at Dermcare available at [www.dermcare.us](http://www.dermcare.us) and posted in the office.

I \_\_\_\_\_ (patient initials) understand that if I email photos or protected health information to this office, Dermcare is only responsible for the content once received in this office and it will become part of your permanent electronic medical record. I also understand that when I leave the practice with my own personal health information such as my visit summary, pre/post operative instructions, etc, it is my responsibility to keep this information private and in safe-keeping.

- We will leave appointment reminders on the preferred contact phone number that you provided at the time of the appointment.

May we leave other medical information on/with?

- |                                      |                              |  |
|--------------------------------------|------------------------------|--|
| Home Answering Machine               | <input type="checkbox"/> Yes | <input type="checkbox"/> No                                  |
| Cell Phone Voicemail                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No                                  |
| Automated Appointment/Reminder Calls | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> Opt out |

Patient Signature _____	Date _____
Print Name _____	
Guardian Signature _____	Date _____
Print Name _____	
Relationship to patient: _____	

- Authorization to discuss my appointments and Health information with:

Name: _____
Relationship _____
Name: _____
Relationship _____
Name: _____
Relationship _____

I decline to give anyone permission to have access to my medical information

\_\_\_\_\_ (Patient initials) \_\_\_\_\_ (Guardian initials)

## Partners Health Care Patient Gateway

[www.patientgateway.partners.org](http://www.patientgateway.partners.org)

Would you like to sign up for our patient gateway? Yes \_\_\_\_\_ No \_\_\_\_\_

Email address \_\_\_\_\_

What does our patient portal do for you???

- You can reach your doctor's office – online
- Stop using the phone for your routine requests
- Request appointments, medicine or referrals
- View lab results
- Ask questions to the doctor, nurse or front desk staff
- Set appointment reminders
- Upload photos to your chart for phone consultation or wound care concerns

**You can access Patient Gateway 24/7 from the convenience of your PC, laptop, cell phone or tablet at your convenience. The MOBILE APP is now available!**



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Patient Label



**Medical History Form (Oculoplastic Surgery)**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
First Middle Last

Referring Provider: \_\_\_\_\_ Your Pharmacy: Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Chief Complaint: \_\_\_\_\_ City, State \_\_\_\_\_

What is the main reason for your visit? \_\_\_\_\_

**Medical History (PROBLEMS):**

List Major Illnesses and Dates				
		(Date)		(Date)
1			6	
2			7	
3			8	
4			9	
5			10	

**Surgical History (PROCEDURES):**

Please List Surgeries and Dates			
1		3	
2		4	

**EYE HISTORY:**

Last Complete Eye Exam: \_\_\_\_\_ Performed by: \_\_\_\_\_  
(Date)

List any Eye Problems or Diseases	List any Eye Medication(s) currently using

**Medications:**

Aspirin:  Yes  No      Plavix:  Yes  No      Coumadin:  Yes  No

List all prescriptions and over the counter medications <b>with doses</b>			
1		4	
2		5	
3		6	

**Allergies to Medications and/or Food:**

Medication	Reaction	Medication	Reaction

Patient Label

**Family History: (Please note if this relates to a family member)**

	Yes	No		Yes	No		Yes	No
Arthritis			Blindness			Crossed Eyes		
Glaucoma			Cataracts			High Blood Pressure		
Thyroid Disease			Heart Disease			Skin Cancer		
Diabetes			Melanoma					

**Review of Systems: (Have you experienced these symptoms within the 30 days?)**

	Yes	No		Yes	No
Blood Sugar Problems			Heart Problems		
Bleeding or Bruising			Joint or Muscle Problems		
Breathing Problems			Loss of Hearing		
Changing Skin Lesion (mole)			Mood Swings or Changes		
Dry eyes			Neurological Problems		
Ear, Nose or Throat Problems			Sensitivity to Bright Light		
Fever			Stomach or Intestinal problems		
			Urinary Problems		

**Social History:**

Per Week:	# Glasses of Wine	# Cans of Beer	# Shots of Liquor
Alcohol Screening			
Smoking Status: (circle)	Never	Former	Current

**Preventative Screening:**

Preventative Screening	Question	Yes	No	N/A	Approx Date
Colorectal Cancer Screening	Have you been screened for colorectal cancer with any of the following methods: either a colonoscopy over the past 9.5 years, or a stool occult blood smear (guaiac test) during this calendar year, or a flexible sigmoidoscopy during the past 4 years and nine months?				
Pneumococcal Vaccination	Have you ever received a Pneumonia Shot?				
Influenza Immunization	Between August and December of this calendar year, did you receive a Flu Shot?				
Breast Cancer Screening (Women only)	Have you had a mammogram within the past 27 months?				
Screening for Osteoporosis (Women only)	Have you ever been screened for Osteoporosis with a bone density scan (DXA or DEXA scan)?				
Urinary Incontinence (Women only)	Over the past 12 months, have you experienced any involuntary leakage of urine (urinary incontinence)?				

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

If form filled out by someone other than patient, list relationship to patient: \_\_\_\_\_

Form Date: 03/08/17

Staff Initials: \_\_\_\_\_

**Directions to our Natick Office:****154 East Central St., 3<sup>rd</sup> Floor****Natick, MA 01760****Phone: (781) 431-0060****Fax: (781) 431-0062****www.dermcare.us****If you are coming from the NORTH:**

1. Proceed along Route 95/128 South
2. Take exit 21B-22 toward MA-16W/Wellesley
3. Merge onto Quinobequin Rd.
4. Turn right onto MA-16W/ Washington St.
5. Continue on MA-135W/East Central St.
6. Northeast Surgery Center will be on the right
7. Parking lot and entrance is in the rear of the building, we are on the 3<sup>rd</sup> Floor

**If you are coming from the SOUTH:**

1. Proceed along Route 95/128 North
2. Take exit 20B to Route 9/Worcester St. for 4 miles
3. Take Weston Rd. exit toward Wellesley (you can turn using either the 1<sup>st</sup> or 2<sup>nd</sup> exit, but must go towards Wellesley)
4. Turn right onto MA-135W/East Central St.
5. Northeast Surgery Center is 2 miles down on the right.
6. Parking lot and entrance is in the rear of the building, we are on the 3<sup>rd</sup> Floor

**If you are coming from the WEST:**

1. Proceed along Route 9 East
2. Make a right on Route 27 South
3. Stay on 27 South to Natick Center
4. At Natick Center, make a left on MA 135 - East Central St.
5. Stay on 135 for less than 1 mile
6. Northeast Surgery Center will be on the left
7. Parking lot and entrance is in the rear of the building, we are on the 3<sup>rd</sup> Floor

**If you are coming from the EAST:**

1. Proceed along Route 9 West and go under Route 95
2. Take the Weston Rd. exit towards Wellesley (you can turn using either the 1<sup>st</sup> or 2<sup>nd</sup> exit, but must go towards Wellesley)
3. Turn right onto MA-135W/East Central St.
4. Northeast Surgery Center is 2 miles down on the right.
5. Parking lot and entrance is in the rear of the building, we are on the 3<sup>rd</sup> Floor

**If you are coming from the NEWTON WELLESLEY HOSPITAL:**

1. Head southwest on MA-16W/Washington St.
2. Merge onto MA-135W/East Central St.
3. Northeast Surgery Center is 2 miles down on the right.
4. **Parking lot and entrance is in the rear of the building, we are on the 3<sup>rd</sup> Floor**