Amanda Auerbach, M.D.
Christine M.Hayes, M.D.
Helen A.Raynham, M.D., Ph.D.
DERMATOLOGIC SURGEONS

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

www.dermcare.us

Suzanne K. Freitag, M.D.
OCULOPLASTIC SURGEON

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

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** 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.** 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
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Members of:
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MetroWest Accountable Healthcare Organization • Emerson Hospital Independent Physician Association • Lowell General Physician Hospital Organization • Steward Healthcare

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PHYSICIANS & SURGEONS

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. ❑ Home Phone ________________ ❑ 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: ❑ White ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American Language Spoken: ________________

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Declined to state ❑ Native Hawaiian or Other Pacific Islander ❑ Declined to state

Employment Status: ❑ Full-time ❑ Part-time ❑ Retired ❑ 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.

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 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 ❑ Yes ❑ No

Cell Phone Voicemail ❑ Yes ❑ No

Automated Appointment/Reminder Calls ❑ Yes ❑ No ❑ Opt out

Patient Signature________________ Date________

Print Name________________

Guardian Signature________________ Date________

Print Name________________

Relationship to patient:________________

Form date: 08/02/17

- 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)

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PHYSICIANS & SURGEONS

Partners Health Care Patient Gateway

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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www.dermcare.us

Patient Label

Medical History Form

Name________________________ ________________________ DOB________________

First Middle Last Preferred Name: ________________

Chief complaint:

What is the main reason for your visit? ________________________________

❑ My doctor referred me for a consultation.

List all medications: (Include names and dosages of prescribed medication, OTC medications, vitamins & supplements)

1.	2.	3.	4.
5.	6.	7.	8.
9.	10.	11.	12.
13.	14.	15.	16.

List allergies to medications and/or food:

Medication/Food	Reaction	Medication/Food	Reaction
1.		2.	
3.		4.	

Past history:

Do you have a pacemaker? ❑ Yes ❑ No

Have you ever had skin cancer? ❑ Yes ❑ No If yes, type? ________________

Do you have a family history of skin cancer? ❑ Yes ❑ No If yes, type? ________________

Do you have a bleeding disorder? ❑ Yes ❑ No

Do you have a history of: (Check if yes)

❑ Tanning ❑ X-ray/Ultraviolet treatments ❑ Arsenic exposure ❑ Immunosuppression/organ transplant

Major illnesses or hospitalizations:________________________________

____

Do you have any artificial joints or take antibiotics prior to dental procedures? ❑ Yes ❑ No

Please list any medical conditions that have occurred in your family? ________________________________

____

____

Social history:

Are you Pregnant? (Women only) ❑ Yes ❑ No

Alcohol Screening: ❑ Wine # Glasses/week ____ ❑ Beer # Cans/week ____ ❑ Liquor # Shots /week ____

Smoking Status: ❑ Never ❑ Former ❑ Current # cigs/day ____

Preventative screening:

Colorectal Cancer ❑ Yes ❑ No ❑ N/A Approx. Date___________

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 ❑ Yes ❑ No ❑ N/A Approx. Date___________

Between August and December of this calendar year, did you receive a Pneumonia Shot?

Influenza Immunization ❑ Yes ❑ No ❑ N/A Approx. Date___________

Between August and December of this calendar year, did you receive a Flu Shot?

Breast Cancer (Women only) ❑ Yes ❑ No ❑ N/A Approx. Date___________

Have you had a mammogram within the past 27 months?

Osteoporosis (Women only) ❑ Yes ❑ No ❑ N/A Approx. Date___________

Have you ever been screened for Osteoporosis with a bone density scan (SXA or DEXA scan)?

Urinary Incontinence (Women only) ❑ Yes ❑ No ❑ N/A Approx. Date___________

Over the past 12 months, have you experienced any involuntary leakage of urine (urinary incontinence)?

Review of symptoms:

Do you have any current or past problems with: (If yes, explain)

Eyes/Glaucoma/Cataracts ❑ Yes ❑ No___________

Ears/Nose/Throat/Mouth ❑ Yes ❑ No___________

Heart/Hypertension ❑ Yes ❑ No___________

Lungs/Asthma ❑ Yes ❑ No___________

Stomach/Gastrointestinal ❑ Yes ❑ No___________

Kidneys ❑ Yes ❑ No___________

Arthritis/Muscles/Joints ❑ Yes ❑ No___________

Headaches/Stroke/Seizures ❑ Yes ❑ No___________

Anxiety Disorder/Depression ❑ Yes ❑ No___________

Thyroid/Diabetes ❑ Yes ❑ No___________

Anemia/Bleeding Disorder ❑ Yes ❑ No___________

Hepatitis/HIV/Tuberculosis ❑ Yes ❑ No___________

I've reviewed all information on this form. Patient Signature: ___________________ Date___________

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

Staff Initials: ________

❑ PCP

All information from this form is entered into your electronic medical record.

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Dermcare Physicians and Surgeons in the
Newton-Wellesley Medical Specialty Center (Waltham) – Boston Children's at Waltham Complex
9 Hope Avenue, **Suite 151**
Waltham, MA
Parking: FREE parking is available in the Children's Hospital parking garage.

Enter the main lobby just past the Micheli Center for Sports Injury.

From the East: If coming from the East (Watertown, Belmont etc) drive West on Main St./Route 20. At the intersection of Route 20 and Route 117 bear left following Route 20 and take an immediate left onto South St. Go 0.3 miles turn left onto Highland St. Follow signs for Newton Wellesley Specialties

From the West: If coming from the West (Weston, etc.) go East on Main St./Route 117. At the intersection of Route 117 and Route 20 turn right onto Route 20 and take an immediate left onto South St. Go 0.3 miles turn left onto Highland St. Follow signs for Newton Wellesley Specialties

From I-95/Rte. 128: I-95/128 (north or south) take exit #26 Waltham/Weston. Follow signs for Route 20 East toward Waltham. Stay on Route 20/Weston St. into Waltham. At first fork bear right onto Vernon St. Turn right onto South St. Turn left onto Highland St. Follow signs for Newton Wellesley specialties

MBTA: The 553 bus route (Moody and Main Streets) stops at the corner of South St. and Shakespeare Rd. Follow the signs to the Newton Wellesley Specialties.

As you enter the lobby, you will see doors to your left. You will enter these doors and walk by the Urgent Care desk, down the hallway and our check in window will be on your left.
If you have any difficult with directions, please call: (781) 431-0060 and hit 1 for assistance.

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