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

Suzanne K. Freitag, M.D.
OCULOPLASTIC SURGEON

dermcare
PHYSICIANS & SURGEONS

www.dermcare.us

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

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

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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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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!

PARTNERS
PATIENT GATEWAY

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

27 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

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Patient Label

Medical History Form

Name _____ DOB _____
First Middle Last

Preferred Name: _____

Address _____ City _____ State _____ Zip _____

Your Pharmacy Name _____ City _____ Phone _____

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)

❑ Medication list attached	4.
1.	5.
2.	6.
3.	Need more room? Continue on bottom of page 2.

List allergies to medications and/or food:

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

Past history:

Do you have a pacemaker? ❑ Yes ❑ No

Have you ever had non-melanoma skin cancer? ❑ Yes ❑ No If yes, type? _____

Do you have a family history of melanoma? ❑ Yes ❑ No If yes, type? _____

Do you have a history of melanoma? ❑ Yes ❑ No If yes, type? _____

If yes, is this being monitored by another provider? ❑ Yes *7010F with 3P* ❑ No

If yes, do you have a regularly scheduled follow up appointment to monitor the diagnosis? ❑ Yes *7010F* ❑ No *7010F with 8P*

If yes, has imaging been ordered in regards to the diagnosis? ❑ Yes *due to additional reason* ❑ No *3320F*

Do you have a bleeding disorder? ❑ Yes ❑ No

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

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

Major illnesses or hospitalizations: _____

_____

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

Social history:

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

Are you planning a Pregnancy? (Women only) ❑ Yes ❑ No

Tobacco Use:

Please choose the option that best describes your tobacco use:

Ages 21+	❑ Non-smoker *1036F*	❑ Current smoker *4004F*	❑ Smoking Cessation Education Provided
Ages 20 & under	❑ Non-smoker *G9459*	❑ Current smoker *G9458*	❑ Smoking Cessation Education Provided

Vaccinations:

Between August 1st and December 31st of this calendar year, did you receive the following vaccinations?

Flu Vaccine ❑ Yes *G8482* ❑ No *G8483* If no, why not? ❑ Too early ❑ Received it last year

❑ Other _____

Ages 65+ only

Pneumonia Vaccine ❑ Yes *4040F* ❑ No *4040F 8P*

Do you currently have an Advanced Care Plan/Health Care Proxy? ❑ Yes *1123F* ❑ No *1124F*

*If yes, who?*_____ *Contact #*_____

What is their relation to you? _____

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 have reviewed all information on this form. Patient Signature: _____ Date _____

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

Medications Continued:

7.	11.
8.	12.
9.	13.
10.	14.

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