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

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 Physicians Association • Lowell General Physician Hospital Organization • Steward Healthcare
GENERAL PATIENT INFORMATION

Patient Name: ___________________________ Preferred name: ___________________________

Date of Birth: _________ SSN: ___________ Marital Status: _______ 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 safekeeping.

[ ] 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: 09/02/17

[ ] 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)
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!
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

1. ___________________________

2. ___________________________

3. ___________________________

Need more room? Continue on bottom of page 2.

List allergies to medications and/or food:

<table>
<thead>
<tr>
<th>Medication/Food</th>
<th>Reaction</th>
<th>Medication/Food</th>
<th>Reaction</th>
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<tr>
<td>1.</td>
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<tr>
<td>2.</td>
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<td>4.</td>
<td></td>
</tr>
</tbody>
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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/Glucoma/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.__________________________________________
8.__________________________________________
9.__________________________________________
10.__________________________________________
11.__________________________________________
12.__________________________________________
13.__________________________________________
14.__________________________________________

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

Updated 3/14/18