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

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

*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*

dermcare™
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:____________________

- 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)

Form date: 08/02/17

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Partners Health Care Patient Gateway

www.patientgateway.partners.org

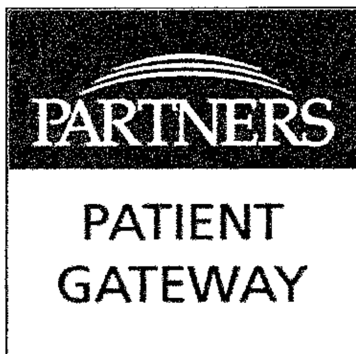
Would you like to sign up for our patient gateway? Yes ____ No ______

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!



Patient Label

Surgery Consultation Form

Name: ____ Date of Birth ____/____/_____
First Middle Last

Your Pharmacy: Name ____
Street ____
City, State ____

Chief Complaint

What is the main reason for your visit?

My doctor referred me for a consultation for a skin cancer that was biopsied in his/her office:
□ Basal cell carcinoma □ Melanoma □ Squamous cell carcinoma
□ Other ____________________________

I have a skin lesion that needs to be evaluated further (Has not been biopsied):
□ Changing Mole (location) __________________ □ Skin Lesion (Location) ____________________
□ Other (Describe) ____

My Skin Cancer History

□ Basal Cell □ Squamous Cell □ Melanoma □ Other ____________________________

List All Medications (Include names and dosages of prescribed medications, OTC medications, vitamins, and supplements.)

1. Aspirin □ yes □ no	2. Plavix □yes □ no	3. Coumadin □yes □ no	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.	

Patient Label

Medical History (previous and current health conditions)
Have you ever had any of the following?

	Yes	No		Yes	No
Artificial Joint			Hypertension		
Atrial Fibrillation			Keloids		
Blistering Sunburn in the past			Leukemia		
Blood Clot or DVT			Liver Disease		
Cancer- Type ______			Low Platelets		
Cardiac Pacemaker/Defib			Lupus		
Chronic Kidney Disease			Memory Loss		
Chronic Lung Disease			Non healing surgical wound		
Clotting Disorder			Organ Transplant		
Coronary Artery Disease			Psychiatric Disorder		
Diabetes			Staph Infection or Other infection after a prior surgery		
Heart Attack			Stroke/TIA		
Heart Bypass			Visual Impairment		
Heart Murmurs					
Hepatitis					
HIV/AIDS					

Family History

Relationship	Abnormal Moles	Melanoma	Basal Cell	Squamous Cell	Skin Cancer (unknown type)
Mother					
Father					
Sister					
Brother					
Maternal Aunt					
Maternal Uncle					
Paternal Aunt					
Paternal Uncle					
Mgrandmother					
Mgrandfather					
Pgrandmother					
Pgrandfather					

Social History

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

Patient Label

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)?				

Review of Systems - Have you experienced any of the following **within the last 30 days?**

Symptom	Yes √	No √	Symptom	Yes √	No √
Constitutional			**Musculoskeletal**		
Fever			Joint Swelling		
Unexpected Weight Change			**Skin**		
HENT			New Rash		
Hearing Loss			New Sores or Wound		
Nose Bleeds			**Allergy/Immunologic**		
Eyes			Immune System weak?		
Sensitivity to Bright Light			**Neurologic**		
Change in Vision			Numbness of Skin		
Respiratory			**Hematologic**		
Cough			Enlarged Glands		
Cardiovascular			Do you bruise easily		
Leg Swelling			**Psychiatric**		
			Are you nervous or anxious		

Patient signature: ______________________________ Date: ________________

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

Form date 03/08/17

Staff Initials: ________________

☐ **PCP** ☐ **Referring Derm**