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

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Patient Label

Medical History Form (Plastic Surgery)

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

Referring Provider: _____ Primary Care physician: _____

Your Pharmacy: Name: _____
Address: _____ City, State: _____

Chief Complaint:
What is the main reason for your visit? _____

Medical History: **Your Height** _____ **Your Weight** _____

	Yes	No	Comments
Cardiovascular Disease - (Heart Disease)			
Diabetes			
Hypertension (High blood pressure)			
History of Heart Attack			
Chronic Obstructive Pulmonary Disease			
Back Problems			

Have you ever had any of the following?

	Yes	No		Yes	No		Yes	No
AIDS/HIV			**Depression**			**Poor healing**		
Anemia			**Diabetes**			**Rheumatic Fever**		
Anxiety			**Glaucoma**			**Skin Cancer including Melanoma**		
Arthritis			**Heart Disease**			**Stents**		
Asthma			**Heart murmur**			**Stomach ulcers**		
Atrial fibrillation			**Hepatitis**			**Stroke**		
Bleeding problems			**High Blood Pressure**			**Thyroid Disease**		
Blood Clots/Embolism			**Kidney Disease**			**Breast Biopsies**		
Cancer			**Pacemaker/Defibrillator**			**Significant weight loss/gain**		

Surgical History (PROCEDURES):

	Please List Surgeries and Dates		
1		**3**	
2		**4**	

Medications:
Circle applicable: Aspirin Plavix Coumadin/Warfarin Eliquis Xarelto Pradaxa

	List all prescriptions and over the counter medications **with doses**		
1		**4**	
2		**5**	
3		**6**	

Patient Label

Allergies to Medications and/or Food:

Medication	Reaction	Medication	Reaction

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

	Yes	No		Yes	No		Yes	No
Breast Cancer			Skin Cancer			Diabetes		
Heart Disease			Melanoma			Kidney Disease		

Review of Systems:

(If you have you experienced these symptoms within the last 30 days, please circle)

General	anemia	fevers	night-sweats	weight-loss	swollen glands
Breast	lumps	discharge	pain		
Ears	ringing	hearing loss	infections		
Eyes	blurring	double vision	cataracts	glaucoma	
Nose/Sinus	infections	bleeding			
Throat	infections	hoarseness	trouble swallowing		
Endocrine	thyroid problems	cold intolerance	heat intolerance		
Lungs	cough	phlegm	coughing up blood	short of breath	
Heart	chest pain	palpitations	ankle swelling		
Vascular	leg cramps	varicose veins	phlebitis	blood clots	
Gastro	nausea	vomiting	diarrhea	constipation	change in bowels
Gastro (con't)	hemorrhoids	hepatitis			
Skin	rash	easy bruising	poor healing	itching	Changing mole
Urinary	frequency	burning urination	blood urine	kidney stones	infections
Bone/Joint	pain	stiffness	swelling	limited motion	
Nervous Sys	seizures	tremors	Fainting/ black-outs	numbness	weakness
Nervous (con't)	dizziness	trouble speaking	anxiety	depression	

Please answer the following questions:

Do you have any Dermal Piercings: (circle) No Yes if yes: location _____ metal or plastic?

Last menstrual cycle: (if applicable) _____

Have you ever had an allergy to contrast dye (circle) Yes No n/a

Patient Label

Social History:

Occupation: _____ Employer: _____

Marital Status: S M D W # of Children/ages of Children _____

Preventative Screening:

Alcohol Screening	# Glasses of Wine	# Cans of Beer	# Shots of Liquor
How many drinks per week?			
Smoking Status (circle)	Never	Currently Smoking	Former Smoker
		How many Packs per day:	Date: Quit

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)?				

I verify that the above information is true and accurate to the best of my knowledge. I consent to the use of my records and photographs for treatment, educational, credentialing and laboratory testing purposes.

Patient signature: _____ Date: _____

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

Staff Initials: _____

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Directions to our Chelmsford Office:
27 Village Square
Chelmsford, MA 01824
(978) 244-0060
(978) 244-2522
www.dermcare.us

If you are using a GPS, please use the address of 16 Fletcher Street, Chelmsford, MA 01824 and it will bring you to 27 Village Square.

Traveling on I 495 North:
Take I 495 north to exit 33, (Route 4 Chelmsford). Take a right off of the exit onto North Road. Take your first left hand turn onto Fletcher Street and then a right into Village Square Professional Park. Our office is at the far-right hand corner near the mail boxes number 27 Village Square.

Traveling on I 495 South:
Take I 495 south to exit 34 (Route 110 West). Take a slight right off of the exit onto Chelmsford Street. At the second set of lights, turn right onto Fletcher Street and then a left into Village Square Professional Park. Our office is at the far-right hand corner near the mail boxes number 27 Village Square.

Traveling on Route 2 West:
Take Route 2 west to I 495 north exit 40B (Lowell/Lawrence). Follow I 495 north to exit 33 (Chelmsford/Bedford). Take a right off of the exit onto North Road. Turn left onto Fletcher Street (at the Eastern Bank) and then takes a right into the Village Square Professional Park. Our office is at the far-right hand corner near the mail boxes number 27 Village Square.

Traveling on Route 2 East:
Take Route 2 East to I 495 north exit 40B (Lowell/Lawrence). Follow I 495 north to exit 33 (Chelmsford/Bedford). Take a right off of the exit onto North Road. Turn left onto Fletcher Street (at the Eastern Bank) and then takes a right onto the Village Square Professional Park. Our office is at the far-right hand corner near the mail boxes number 27 Village Square.

Traveling on I93 North:
Take I 93 north to I 495 south exit 44B (Lowell). Follow I 495 south to exit 34 (Route 110 West). Take a slight right off of the exit onto Chelmsford Street. At the second set of lights, turn right onto Fletcher Street and then a left into Village Square Professional Park. Our office is at the far-right hand corner near the mail boxes number 27 Village Square.

Traveling on I93 South:
Take I 93 south to I 495 south exit 44B (Lowell). Follow I 495 south to exit 34 (Route 110 West). Take a slight right off of the exit onto Chelmsford Street. At the second set of lights, turn right onto Fletcher Street and then a left into Village Square Professional Park. Our office is at the far-right hand corner near the mail boxes number 27 Village Square.

Traveling on Route 128/95 North:
Take I 95/MA 128 north to Route 3 north exit 32A (Lowell/Nashua). Follow Route 3 north to exit 30C/495 south (Chelmsford/Marlborough). Take I 495 south to exit 34 (Route 110 West). Take a slight right off of the exit onto Chelmsford Street. At the second set of lights turn right onto Fletcher Street and then a left into Village Square Professional Park. Our office is at the far right hand corner near the mail boxes number 27 Village Square.

Traveling on Route 128/95 South:
Take I 95/MA 128 south to Route 3 north exit 32A (Lowell/Nashua). Follow Route 3 north to exit 30C/495 south (Chelmsford/Marlborough). Take I 495 south to exit 34 (Route 110 West). Take a slight right off of the exit onto Chelmsford Street. At the second set of lights turn right onto Fletcher Street and then a left into Village Square Professional Park. Our office is at the far right hand corner near the mail boxes number 27 Village Square.