

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



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 and Surgeons is dedicated to providing our patients with the best care available. For your convenience, we have scheduled you for a telephone consultation which will alleviate you having to schedule an in office visit prior to your surgery. Enclosed please find important information that you should review prior to your schedule telephone call.

It will be necessary to provide a photograph of the site of surgery. We have included a tip sheet to help you take your photograph which should be emailed to: photo@dermcare.us

Please arrive 10 minutes prior to your appointment with your completed paperwork.

The packet includes:

Patient Registration & Privacy Form
Patient Gateway Sign up sheet
Tips on how to take a photograph of the site of surgery
The questions you need to be prepared to answer during your call

For more information about our practice, please visit us at www.dermcare.us. Our Website provides detailed information about our physicians and our services.

If your address, phone number or insurance information has changed, please be sure to alert the front office staff.

If for any reason, you are unable to be available for your scheduled telephone consultation appointment, it is imperative that you call us 24 hours in advance to cancel or reschedule so that we can offer your slot to another patient.

If you would like to correspond with our office via email regarding your care and treatment, please sign up to our new 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
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MetroWest Accountable Healthcare Organization • Emerson Hospital Independent Physician Association • Lowell General Hospital Organization • Steward Healthcare



APPOINTMENT TIPS

Breast Lifts & Breast Augmentation/Enlargement

(Loreen Ali, M.D.)

Being organized and focused will help you get the most satisfaction and communication from your visit. Here are a few tips to help you prepare for the dialogue.

Before your appointment

Write down all of the questions you want to ask your physician that you think are the most important to you.

Things to bring with you for your visit

Please bring your completed new patient forms

If you think you might feel more comfortable, bring a friend or relative who can help take notes or ask questions for you

If you are coming in for ***breast augmentation/enlargement***, on the day of your office visit, please wear a regular (not padded) bra and bring a tight white or black shirt.

If you are age 40+, you will need to have received a mammogram within the last six months.

If you have had one, please bring a copy of your mammogram report with you to your visit.

If you have not had one, you will need to arrange with your primary care physician to have one performed prior to your procedure.

More Information on our website

Our website www.dermcare.us will provide many details regarding our physicians and our practice.

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. <input type="checkbox"/> Home Phone _____ <input type="checkbox"/> 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: <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American Language Spoken: _____			
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined to state <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Declined to state			
Employment Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> 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)

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Partners Health Care Patient Gateway

www.patientgateway.partners.org

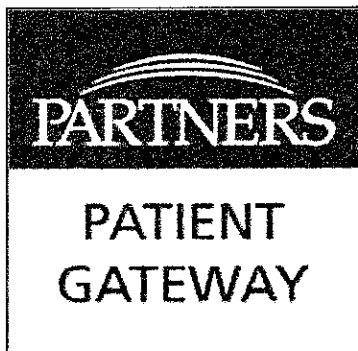
Would you like to sign up for our patient gateway? Yes _____ No _____

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!



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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

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: _____

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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.

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