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 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

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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:_____

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

Please email photo to: photo@dermcare.us

In the SUBJECT line, please include ONLY the first 3 letters of your LAST name and your patient ID #. Your unique patient ID number will be included in the phone consultation packet that we will send to you either by email or regular mail.

Below is an example email sent to us from Mrs. Jane Doe:

Send | doe#12345 | Save

To: photo@dermcare.us

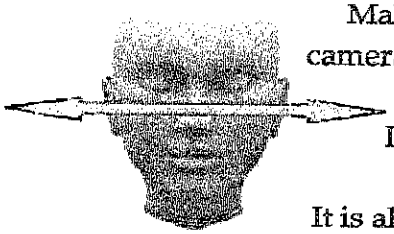
Cc/Bcc:

Subject: doe#12345

insert photo here 

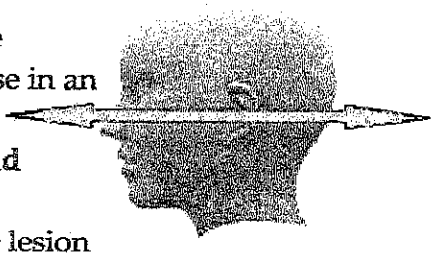
How do I take the Consult Photo?

HEAD PHOTOS:



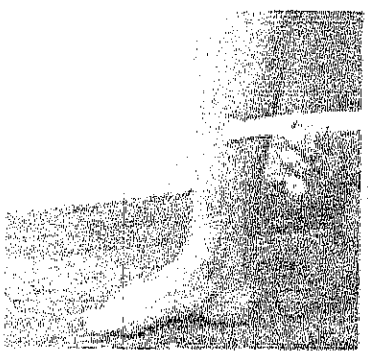
Make sure your head is straight and facing the camera directly. Ears should be lined up with nose in an imaginary straight line.

It is important to take both a front view and a side view photo.



It is also very important to have a **close up** of the lesion next to the ruler found on the right side of this page.

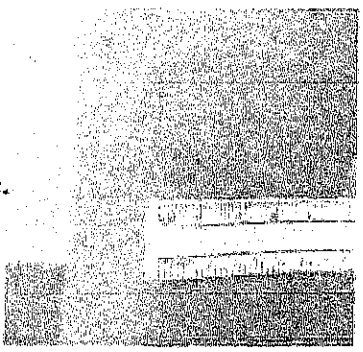
OTHER BODY PART PHOTOS:



The size of your lesion is very important to us, as it will help us determine what treatment is best for you.

Please send us a **close up** of your lesion, lined up next to the ruler found on the right side of this page.

Be careful not to cover the lesion with the ruler.



Please make sure to take a **distant shot** of the same lesion, as it will help us identify the anatomical location on the day of surgery.

Patient Telephone Consultation Questions

Please be prepared to discuss the following Information during your telephone consultation

- Site/s to be treated 1)
  2)
  3)
  4)
- Are you able to identify the site/s?
- Did you email photo of biopsy site/s to the office?
- We will review your medication list (prescriptions, over the counter medications, vitamins, and supplements, please include dosages of each)
- We will review your medical history (previous and current health conditions)
- Any new medical conditions that we may need to be aware of since the last time you were seen in our office? If yes, what?
- Do you have any allergies to medications or food?
- What is your current smoking status? Have you ever smoked?
- Do you have a pacemaker/defibrillator?
- Do you take any antibiotics prior to dental work? If yes, why?
- Do you have any family history of skin cancer?

Form date: 10/10/13

Patient Label

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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**