THE DERMATOLOGY CENTER OF NEW JERSEY, PC

1. Patient Information - Print All Answers

Full Name : *(last/first)*	
Date of Birth:	
Address: *(street/city/state/zip or po box)*	
Home Tele#:	
Cell #:	
Work Tele#:	
Email:	
Emergency Contact/Tele#: *(name/tele/relation)*	
Referred by:	
Preferred Pharmacy Name: *(city/state)*	

2. Gender Identity (*circle appropriate category*)

Male

Female

Genderqueer (*neither exclusively male nor female)*

Female-to-Male (**FTM**)/Transgender Male

Male-to-Female (**MTF)**/Transgender Female

3. Demographic Information *(circle appropriate category)*

American Indian or Alaska Native

Asian or Asian Indian

Black or African American

Native Hawaiian or Pacific Islander

White

Declined to Specify

4. Ethnicity *(circle appropriate category)*

Hispanic or Latino

Not Hispanic or Latino

Declined to Specify

5. Insurance Information

Responsible Party/Guarantor : *(Full Name)*	
Date of Birth/SSN:	
Primary Insurance Name/Policy ID:	
Secondary Insurance Name/Policy ID:	
Prescription Insurance Name/Policy ID:	

6. Patient Acknowledgement & Authorization for Release of Information

I, (**patient/guarantor**) consent to all health care treatments, diagnostic procedures, and any other tests provided by **The Dermatology Center of New Jersey** and its associated physicians, clinicians, and other personnel. I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations.

I **(patient/guarantor)** agree to be contacted via email or text with information related to my visit, via patient-portal, post-visit services appointments, follow-up reminders or any new services related to the practice that relate to me or my family.

I **(patient/guarantor)** consent to the use and disclosure of my protected health information for purposes of obtaining payment for services rendered.

Initials: _____

7. Co-payments, Deductibles & Self-Pay

I**, (patient/guarantor)** am required and responsible for all payments at the time services are rendered.

Initials: _____

8. Advance Beneficiary Notice of Non-Coverage – Medicare Patients Only

I, **(patient)** understands that Medicare does not pay for some procedures. If Medicare does not pay, payment becomes my responsibility.

Initials: _____

9. Co-payments, Deductibles & Self-Pay

I, (**patient/guarantor**) am required and responsible for all payments at the time services are rendered.

Initials: _____

10. Referrals

I, **(patient/guarantor**) am required and responsible to obtain the referral form and to assure it is presented at the time of my service. Furthermore, it is my responsibility to keep track of #office visits and expiration date.

Initials: _____

11. Cancellation, Reschedule & No- Show Policy

Should you (**patient/guarantor**) be unable to keep your appointment, please contact our office at minimum of 2.5 hours before the scheduled appointment. Failure to notify this office in a timely-manner will result in a **$50 No-Show fee.** Late-arrivals of more than 15 minutes without notification will be cancelled.
This fee is your responsibility

Initials: _____

12. Insurance Cards

New or Established Patients with a change in their insurance must provide a valid insurance card physically/digitally At the time of service. Should you be unable to provide this documentation, patients may pay in full as self- pay. Self-pay patients with insurance that is not in network can submit Health Insurance Claim Form to their insurance carrier.

Initials: _____

13. HIPAA Policy

Patients over the age of 18 are protected under the **Federal Health Insurance Portability and Accountability Act**.

Name of Individual	Relationship t Patient

Print Name of Signee: _____

Full Signature Name Required: _____

Date:_____

The Dermatology Center of New Jersey, PC

HEALTH HISTORY

Welcome to the office of Dr. Agarwal. Good skin health requires a broad understanding of your past and present health. Please complete the following questionnaire. Thank you!

Name:_____ Birth Date: _____ Age: ____ Sex: M F Date: _____

What is the reason for your visit today: 1) _____

2)_____

Occupation: _____

Have you had any of the following conditions in the past? Please place a check mark next to them.		**Do you currently have any of the following conditions? Please place a check mark next to them.**		**Please check any of the following conditions which a family member (parents, children, grandparents) may have had.**	
skin cancer		itchiness		skin cancer	
melanoma		dry skin		melanoma	
atypical moles (dysplastic nevus)		oily skin		atypical moles (dysplastic nevi)	
basal cell carcinoma		irritated lesions		acne	
squamous cell carcinoma		changing lesions		eczema	
actinic keratosis T-		fever		psoriasis	
cell lymphoma		fatigue		lupus	
other cancer		sweats		other cancer	
diabetes		dry eyes		diabetes	
sarcoid		nose bleeds		sarcoid	
heart disease		swelling in hands or feet			
stroke/TIA		wheezing			
seizures/epilepsy		abdominal pain			
thyroid disease		joint pain			
lupus		headache			
hepatitis/liver disease		depression			
herpes simplex		recent weight gain			
bleeding disorder		recent weight loss			
Crohn's/colitis disease		swollen glands			
heart valve		itchy eyes			
pacemaker					
hip replacement					
cataracts					
glaucoma					
kidney/renal disease					
GYN problems					
depression					

HEALTH HABITS:

Do you smoke? No ___ Yes ____ Quit ____

Number of packs per day? _____

Do you drink alcohol? Y N

If yes, how many drinks a day?

0-1 ___ 2 or more ___

Do you use any illegal drugs? Y N

If yes, which drugs? _____

Do you spend long hours in the sun? Y N

Have you ever had a blistering sunburn? Y N

Referring MD:

Address/City: Phone Number:

CURRENT MEDICATIONS:

Name of Medication	Reason for Taking

PHARMACY INFORMATION:

Name:

Address/City: Phone Number:

ALLERGIES:

Do you have any medication allergies? Y N If yes, please list:

Do you have any other allergies? Y N If yes, please list: _____

For Females Only: Pregnant or Nursing? Y N Trying to Get Pregnant? Y N