New England Dermatology ASSOCIATES

357 Hartford Turnpike, Vernon CT, 06066
PH (860) 871-9441 • FAX (860) 871-0227
www.VernonDerm.com

REGISTRATION INFORMATION

PATIENT INFORMATION **DATE:**

LAST NAME	FIRST NAME	MI	BIRTHDATE

HOME ADDRESS	CITY	STATE	ZIP	SEX: ___ MALE ___ FEMALE

SPOUSE'S NAME	HOME #	WORK #

EMAIL ADDRESS	MOBILE #	MARITAL STATUS: £ MARRIED £ SINGLE ☐ DIVORCED £ SEPARATED £ WIDOWED

RESPONSIBLE PARTY INFORMATION (If other than self)

LAST NAME	FIRST NAME	MI	HOME #

ADDRESS	CITY	STATE	ZIP	SOCIAL SECURITY #

EMPLOYER	OCCUPATION	WORK #

EMPLOYER'S ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO RESPONSIBLE PARTY ☐ SPOUSE £ SON £DAUGHTER

EMERGENCY INFORMATION

NAME	RELATIONSHIP	HOME #

ADDRESS	CITY	STATE	ZIP	WORK #

PRIMARY INSURANCE	SOCIAL SECURITY #	CARDHOLDER	DATE OF BIRTH

GROUP NUMBER	IDENTIFICATION NUMBER	EFFECTIVE DATE

ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

SECONDARY INSURANCE	CARDHOLDER	DATE OF BIRTH

GROUP NUMBER	IDENTIFICATION NUMBER	EFFECTIVE DATE

ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

PHARMACY INFORMATION- Must provide complete address information to ensure your prescriptions are sent to the correct pharmacy.

PHARMACY NAME	PHARMACY PHONE NUMBER

PHARMACY ADDRESS

Patient Contact Preferences
Home Phone: It's ok to leave a message_______
Cell Phone: It's ok to leave a message_________
Work Phone: It's ok to leave a message_______

Patient Contact Preferences
Home Phone: It's ok to leave a message_______
Cell Phone: It's ok to leave a message_________
Work Phone: It's ok to leave a message_______

Email____

Do you give the office of New England Dermatology Associates permission to discuss your medical information

with family members? YES_____ NO____If Yes, Which Family Member?_________Date___

Signature ________________________________ Date __________

HEALTH QUESTIONNAIRE

Date: ______________

Name:____Age:________Date of Birth: ________________

Referred By: ____

Primary Care Physician:____Phone:___________________________

Primary Reason for Your Visit: ____

____

Duration of Problem: ____

Treatment:____

Aggravating Factors: ____

Current Medications (please include over-the-counter, herbs, vitamins, supplements): _______________________

____

____

Allergies to Medication: ☐None ☐ ____

Other Allergies: ☐None ☐Latex ☐Bandages/Adhesive

☐Topical Antibiotic (Neosporin or other) _______________________________________

Have you ever had a bad reaction to local anesthesia? ☐No ☐Yes ☐Never had anesthesia

FOR WOMEN ONLY:

Are you currently pregnant, trying to become pregnant, or are you nursing? _________________________

Are you on a contraceptive, and if so, what form? ____

SKIN CONDITIONS:

Have you ever had skin cancer? ☐No ☐Yes

If Yes, ☐Basal Cell Carcinoma ☐Squamous Cell Carcinoma ☐Melanoma

Where?____When?______________________________

Treatment? ____

Has anyone in your family ever had skin cancer? ☐No ☐Yes

If Yes, ☐Basal Cell Carcinoma ☐Squamous Cell Carcinoma ☐Melanoma

Who? ____

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Do you have any history of skin problems or diseases? ☐No ☐Yes

If Yes, ☐Psoriasis ☐Eczema ☐Keloid ☐Other ____________________

SUN EXPOSURE:

When you are exposed to the sun do you:

☐ always burn
☐ usually burn, tan minimally
☐ sometimes mild burn, tan uniformly
☐ rarely burn, always tan well
☐ very rarely burn, tan very easily
☐ never burn, tan very easily

Where did you grow up? ____________________

Did you: ☐ sunburn every summer in childhood
☐ get at least one blistering sunburn, how many ________
☐ ever use a tanning bed, how many times/how often ________

Do you: ☐ Use sunscreen regularly, SPF ________

PAST SURGERIES (Type and Date): ____________________

____

____

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS:

Allergic/Immunologic: ☐Seasonal allergies ☐Immunosuppression ☐Organ Transplant

Constitutional: ☐Weight loss/weight gain ☐Fever/Night sweats ☐Fainting Cancer:

Type ____________________

Cardiovascular: ☐Normal ☐Artificial Heart Valve ☐Pacemaker
☐Implanted Defibrillator ☐Irregular Heartbeat
☐Chest Pain/Heart attack ☐Mitral Valve Prolapse
☐Other ____________________

Ears/Eyes/Nose: ☐Glaucoma ☐Glasses/Contacts ☐Other ________ Endocrine:
☐Diabetes ☐Thyroid Disease ☐Other ________ Gastrointestinal:
☐Reflux. ☐Liver Problem ☐Nausea, Diarrhea
☐Other ____________________

Genital/Urinary: ☐Enlarged Prostate ☐Prostate Cancer

Family History: ☐Unknown- Adopted

New England Dermatology ASSOCIATES

Hematologic: ☐Anemia ☐Bleeding Problems ☐Other ______________________________

Infections: ☐HIV ☐Hepatitis ☐Tuberculosis/+PPD Skin Test

☐Other ______________________________

Musculoskeletal: ☐Arthritis ☐Artificial Joint ☐Other ______________________________

Neurological: ☐Stroke. ☐Seizures/Epilepsy ☐Multiple Sclerosis

☐Other ______________________________

Respiratory: ☐Asthma ☐Emphysema ☐Other ______________________________

Psychiatric: ☐Depression ☐Anxiety Attacks ☐Other ______________________________

Others: ☐Kidney Problems ☐Cold Sores ☐Varicose Veins

☐Require Antibiotics Prior to Dentistry

Any other medical problems: ______________________________

FAMILY HISTORY: ☐Eczema ☐Psoriasis ☐Other ______________________________

COSMETIC HISTORY: ☐BOTOX Injectable Fillers ☐Laser Treatments

SOCIAL HISTORY:

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow/Widower

Occupation:

____

Smoking: ☐No ☐Former ☐Yes, packs/day ______________________________

Alcohol: ☐No ☐Yes, how much/often ______________________________

Vaccines: ☐Flu ☐Covid ☐Zoster (Shingles)

By signing, I am acknowledging that I have disclosed all of my health information known to me at this time, and all of my other personal information is accurate. I understand that it is my obligation and responsibility to notify New England Dermatology Associates of any changes in my medical information during the course of my medical treatment.

Signature ______________________________ date ______________________________

Print Name: ______________________________

CONSENT FOR PROCEDURES

The undersigned authorizes New England Dermatology Associates to perform dermatology (skin care) services on the patient named below, which may include cancer evaluation and the removal of any suspected cancer lesion, as more fully explained on the second page to this Consent for Procedures; and (ii) to bill the appropriate party (including Medicare and/or other insurance) for such services.
In addition, please review and sign the enclosed HIPAA Patient Consent Form.

PATIENT NAME:

Date:_____________,_______FACILITY NAME: ____

Authorization and Consent of Patient (if patient is unable to provide consent, obtain authorized signature in section below)

PATIENT SIGNATURE: ____

WITNESS SIGNATURE: ____

Authorization and Consent of Legal Guardian or Holder of Power of Attorney

The individual signing on behalf of the patient hereby represents and certifies that he or she holds a valid power of attorney for the patient or is the patient's legal guardian and has the power and authority to execute this consent and authorization for treatment on behalf of the patient.

SIGNATURE: ____

PRINT NAME OF SIGNATORY: ____________________________________

WITNESS SIGNATURE: ____

SIGNATURE____Date ____________________

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CONSENT FOR PROCEDURES

(Continued)

1. My authorization signature on the preceding page hereby authorizes New England Dermatology Associates to perform upon the named patient, medically necessary evaluation of suspicious skin abnormalities, possible biopsy and removal of precancerous and cancerous skin lesions. In addition, I understand and agree with all of the items listed below.
2. If any unforeseen conditions arise during the course of these procedure, I do hereby authorize New England Dermatology Associates personnel to take whatever steps, and to perform whatever procedures they deem advisable which may be in addition to or different from those now planned.
3. I understand that there are always certain risks and consequences that are associated with the aforesaid procedures. These, among others, are scarring, pigmentary changes to the skin, reoccurrence of skin cancer or other lesion/problem, and possible damage to blood-vessels, or parts next to them, such as nerves, infection, or allergic reactions or other complications.
4. I acknowledge that no guarantee or assurance has been made to me as to any of the results or risks, and I assume such risk, and that the practice of medicine is not an exact science, and I understand these facts. I will ask if I want to have further explanation, discussion or description of the risks involved in these procedures.
5. I consent to the disposition by New England Dermatology Associates of any tissue parts, which may be removed from named patient. I understand that this tissue will be sent for pathologic evaluation to a board-certified dermatopathologist and that named patient will be financially responsible for all the charges related to this evaluation regardless of the reimbursement from insurance carrier. I also understand that I will not hold New England Dermatology Associates professionally or personally responsible for the pathologic interpretation of said tissue and that this tissue may be send for additional tests or evaluation at my or my insurance companies' expense.

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Laurie Bain, MD
Amy D. H. Doody, MAS, PAC
Chandranni Quiońes, PA-C

HIPAA Release of Information

Patient Name: ________________________________Date of Birth: _______

Email address: ____

Home Phone#: ________________Cell phone#__________________
Work phone #_________________**Best contact# ___Home ___Cell ___Work**

___Yes, I give my permission to leave detailed information on my voicemail.

OR

___No, please leave a call back number only. Please do not leave a detailed message.

It is okay to discuss my health information with the following family/friend:

______________________________Phone# ________________

______________________________Phone# ________________

______________________________Phone# ________________

This HIPAA Release of Information was signed by:

Signature __________________________ Date _____
Print Name and Relationship to Patient (if other than patient):

Preferred Pharmacy

Pharmacy Name ________________________________

Address ____

City, State, Zip Code___________________________________

Primary Care Doctor: _______________________________

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