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 _____

New England Dermatology ASSOCIATES

HEALTH QUESTIONNAIRE

Date:_____

Name:_____ Age:_____ Date of Birth:_____

Referred by:_____

Primary Care Physician:_____

Primary Reason for Your Visit:_____

_____

Duration of Problem:_____

Treatment:_____

Aggravating Factors:_____

MEDICAL HISTORY:

Vaccines:	_____Flu	_____Covid	_____Zoster (Shingles)
Date Given:	_____	_____	_____

Vaccines:	_____Pneumonia	_____Tetanus (Td/Tdap)
Date Given:	_____	_____

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?_____

New England Dermatology ASSOCIATES

PLEASE CHECK AND MEDICAL CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST:

_____Anemia	_____Anxiety	_____Arthritis
_____Artificial Heart Valve	_____Artificial Joints	_____Asthma
_____Bleeding Problems	_____Cancer	_____Chest Pain/Heart Attack
_____Cold Sores	_____Depression	_____Diabetes
_____Diarrhea	_____Emphysema	_____Enlarged Prostate
_____Fainting	_____Fever/Night Sweats	_____Glaucoma
_____Hepatitis	_____HIV	_____Immunosuppression
_____Implanted Defibrillator	_____Irregular Heartbeat	_____Kidney Problems
_____Liver Problem	_____Mitral Valve Prolapse	_____Multiple Sclerosis
_____Nausea	_____Organ Transplant	_____Pacemaker
_____Reflux	_____Require Antibiotics Prior to Densitry	
_____Seizure/Epilepsy	_____Stroke	_____Thyroid Disease
_____Tuberculosis/+ PPD Skin Test	_____Varicose Veins	_____Weight Loss or Gain

Any other medical conditions?_____

SKIN CONDITIONS:

Have you ever had skin cancer? _____Yes _____No

If yes: _____Basal Cell Carcinoma _____Squamous Cell Carcinoma _____Melanoma

Where?_____ When?_____

Treatment?_____

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 _____

COSMETIC HISTORY:

Have you had: _____BOTOX Injectable Fillers _____Laser Treatments

FAMILY HISTORY: _____Unknown
Has anyone in your family ever had skin cancer?_____Yes _____No
If Yes: _____Basal Cell Carcinoma _____Squamous Cell Carcinoma _____Melanoma
Relation to you?_____

Has anyone in your family ever had _____Eczema _____Psoriasis Other_____

ALLERGIES TO MEDICATION: _____None
Please list:_____

_____

Other Allergies: _____None _____Latex _____Bandage/Adhesive

_____Topical Antibiotic (Neosporin or other)_____

Have you ever had a bad reaction to local anesthesia? _____No _____Yes _____Never had anesthesia

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

Name_____Dosage_____
Frequenccy_____

Name_____Dosage_____
Frequenccy_____

Name_____Dosage_____
Frequenccy_____

Name_____Dosage_____
Frequenccy_____

Name_____Dosage_____
Frequenccy_____

Name_____Dosage_____
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Name_____Dosage_____
Frequenccy_____

Name_____Dosage_____
Frequenccy_____

Name_____Dosage_____
Frequenccy_____

Name_____Dosage_____
Frequenccy_____

Name_____Dosage_____
Frequenccy_____

Name_____Dosage_____
Frequenccy_____

SOCIAL HISTORY:

Marital Status: _____Single _____Married _____Divorced _____Widowed

Occupation:_____

Do you smoke? _____No _____Former _____Yes, packs per day_____

Do you drink alcohol? _____No _____Yes, how much/often_____

For men under 65: Have you had 5 or more drinks in a day in the past year? _____Yes _____No

For women and men 65 and older: Have you had 4 or more drinks in a day in the past year?
_____Yes _____No

PAST SURGERIES: (Type and Date)

_____

_____

_____

_____

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_____

Print Name_____

Date_____

POLICY & CONSENT FORM

Note: If the patient is a minor, then the responsible party, legal guardian or the insured is responsible

PATIENT RESPONSIBILITY: Insurance/Billing - In order for New England Dermatology Associates to submit clean claims in a timely manner and avoid denials for unauthorized services, untimely claims, etc., the patient must provide complete, current and accurate insurance and billing information prior to services; Referrals - If required, the patient must provide referrals prior to services; Patient must provide requested information - Upon request, the patient must provide information to the physician office and to the insurance, as needed for claims processing. When claims are denied because the patient did not comply as instructed above, the patient will be responsible for payments in full. We will not submit appeals in these cases. BILLING POLICY: Payment in full is due by the due date on the bill, unless other arrangements are made with our office. If an account is referred for collection, the patient will be billed for the cost of collections fees. Future services could be terminated.

AUTHORIZED CONTACTS are people with whom we may discuss appointments, medical care, account information, etc. Names, phone #'s, fax #'s, emails & mailing addresses of the Responsible Party, Emergency Contact and Insurance Members provided are considered as authorized contacts. You may provide additional contacts. These contacts remain in effect until revoked in writing.

ASSIGNMENT OF BENEFITS

Medicare: /if **applicable**

I request that payment of authorized Medicare benefits be made on my behalf to New England Dermatology Associates. I authorize any holder of medical information about me to release to the Centers for Medicare Services and its agents, any information needed to determine these benefits payable for related services. I understand that I am responsible for applicable Medicare Part B deductible, coinsurance amounts and any non-covered services.

Insurance: (if applicable)

I request that payment of any authorized insurance benefits to be made on my behalf to New England Dermatology Associates. I authorize any holder of medical information about me to release to my insurer, any information needed to determine benefits payable for services from this provider. I understand that I am responsible for any co-pay, ca-insurance, deductible and non-covered services.

Self-Pay if **applicable**

I understand that I am responsible for payment in full at the time of services unless other arrangements are made with New England Dermatology Associates. I also understand that if I do not provide insurance information required for filing claims that my account will default to 'self-pay'.

PATIENT CONSENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this form, I give consent to New England Dermatology Associates and representatives to use and disclose my protected health information as needed to carry out treatment; provide continued care; carry out healthcare operations; and to collect payments for services rendered. New England Dermatology Associates and representatives may contact me or leave a message at my home or other location by phone, fax, email, mail or other location. I have the right to request that New England Dermatology Associates restrict how they use or disclose my information. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by that agreement. If I do not sign this consent, or later revoke it, New England Dermatology Associates may decline to provide treatment to me. A copy of New England Dermatology Associates Notice of Privacy Practices will be made available to me upon request.

MEDICAL CONSENT

I request and authorize my physician and her associates, assistants and staff to provide and perform such medical care, tests, procedures, drugs and other services and supplies as considered advisable by my physician for my health and well-being. This may include pathology, radiology, emergency services, prescriptions, and other special services and tests ordered by my physician. I acknowledge the no representatives, warranties, or guarantees as to results or curves have been made to or relied upon me. By signing below, I acknowledge that I have read, understand and agree to the policies outlined on this page. This consent remains In effect until I revoke it in writing.

Patient Name _____ date _____

Patient Signature or Responsible Party Print Responsible Party Name _____

New England Dermatology ASSOCIATES

Laurie Bain, MD
Amy D. H. Doody, MAS, PAC
Chandranni Quioñes, 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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