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

The Dermatology Center of NJ
Dr. Smita Agarwal

Patient Registration **Please print and answer all questions in full.** **Date:**

Patient Information (please complete using your name as listed on your insurance card)

Name: Last _____First_____Middle Initial_____

Address _____City_____ State_____ Zip_____

Home Phone _____ Cell Phone_____ Work Phone _____

Sex: M_____ F _____ Birth date _____

Employer_____

Emergency Contact: _____Relation to Patient_____ Phone _____

Referred by: Doctor_____ Phone #_____

Email Address: _____Pharmacy/loc:_____

Primary Insurance

Name of Insurance Company _____ policy#_____

Insured Name: Last_____First_____Middle Intial_____

Insured DOB _____ SSN #_____ Relationship to Patient_____

Insured Employer _____Cell Phone _____Work Phone_____

Secondary Insurance

Is Patient covered by additional insurance? Yes_____ No_____

Name of Insurance Company _____ policy#_____

Insured Name: Last_____First_____Middle Intial_____

Insured DOB _____ SSN #_____Relationship to Patient_____

Insured Employer _____Cell Phone _____Work Phone_____

Patient Release

Must be signed by patient if over18 or legal guardian of patient under 18

I certify that the information that I have provided is correct. I authorize the release of medical information as necessary to process claims to companies or their agencies (including Medicare) for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider.

I certify that I hereby authorize The Dermatology Center, its providers and staff to provide my minor child in my absence with examinations and basic treatment for which additional consent is not required. I understand as the legal guardian of this child I am required to be physically present to consult with the provider on any procedures which require separate consent such as surgery, biopsy or wart destructions. I understand that additional written consent may be necessary for these types of procedures and that the legal guardian must be present for such consent.

Signature:_____Today's Date:_____

Patient Acknowledgements of The Dermatology Center Office Policies

Insurance Information

Co-payments and Deductibles

Payment is required for all services at the time they are rendered. All applicable co-payments and deductibles will be collected at the time of service. An administrative billing fee of $10 will be applied if co-payments are not paid at the time of service. In the event that your account must be turned over for collections interest and/or a collection fee, at the provider's current rate may be charged on all balances owing to the provider that are past due. Your signature below signifies your understanding and wiliness to comply with this policy.

_____ _____

Patient Signature Date

Referral Information

If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my Primary Care Provider and assure it is available to be presented at the time of my visit. I further understand it is my responsibility to keep track of the number of visits I have used on my referral and the expiration date of my referrals and obtain new ones as needed. I understand that should I fail to have a valid referral for my visits; The Dermatology Group will reschedule my appointment.

_____ _____

Patient Signature Date

Insurance Cards

New patients or those patients with a change in their insurance information must provide a valid insurance card or temporary print out at the time of the visit. Should you be unable to produce this documentation, patients may pay in full at the time of service and submit the claim to your insurance carrier at your convenience for reimbursement. I understand by signing below that I am responsible for notifying the office of any changes to my insurance or contact information.

_____ _____

Patient Signature Date

Cancellation Policy

Should you be unable to keep your appointment, please contact our office to cancel your appointment. Failure to contact the office will result in a $25.00 fee. This fee is not reimbursable by your insurance company.

_____ _____

Patient Signature Date

HIPAA Policy

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of The Dermatology Group from discussing appointments, medication, test results or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information. Should you wish to update the names provided below, please ask the receptionist for a HIPAA Form.

Name of Individual (please print)	**Relationship to Patient**

I acknowledge having received a copy of the practice's Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996.

_____ _____

Patient Signature Date