D. NEAL MASTRUSERIO, M.D., LLC

Patient Information (Please print clearly)

Name _____
Last First MI

Address _____

City _____ State _____ Zip _____

Phone# ( ) _____

SSN _____ M _____ F _____

DOB _____ Age _____ Marital Status M S W D

Email: _____

Cell# _____ Cell Provider:_____

Preferred appointment confirmation: email/text or phone

May we contact you for cosmetic sales & promotions: Yes No

Pref. Language: English Spanish Amer. Sign Language Other Decline
Race: Asian Black Caucasian Hispanic Nat. Amer. Other Decline
Ethnicity: Hispanic Non-Hispanic Other Decline

Your Employer_____

Address _____

Phone# ( ) _____

Family Doctor _____

Phone# ( ) _____

Referring Doctor _____

Phone# ( ) _____

Pharmacy Name & Phone_____

Spouse's Name _____

By providing my email address, I authorize your office to contact me via the email address(es) provided.

Emergency Contact (Nearest friend or relative)

Name_____Phone # ( ) _____

Address _____

Guarantor Information (Responsible party i.e. parent or legal guardian)

Name _____

Address (if different)_____

City, State, Zip_____

Phone# ( ) _____

Relationship _____

Employer _____

Address_____

Phone# ( ) _____

Primary Insurance Information

Insurance Co._____

Policy Holder _____

Relationship _____

SSN _____

Insured's Date of Birth _____

Employer Name & Phone #_____

Subscriber ID# _____

Group #_____

Co-Pay or Coinsurance Amount _____

Secondary Insurance Information

Insurance Co_____

Policy Holder _____

Relationship _____

SSN _____

Insured's Date of Birth _____

Employer Name & Phone #_____

Subscriber ID# _____

Group #_____

Co-Pay or Coinsurance Amount _____

The undersigned hereby authorizes treatment of the above named patient. I/we agree to promptly pay all charges for the patient, at the time of service unless other arrangements have been made with the billing department. The undersigned hereby authorizes release of any information pertaining to a claim filed with his or her insurance company. D. Neal Mastruserio, M.D., LLC is not responsible for procedures not covered by your insurance company. We will provide you with a statement. You are responsible for the bill.

Signature_____ Date_____

D. Neal Mastruserio, M.D., L.L.C.

General Dermatology
Adult & Pediatric – Medical, Surgical & Cosmetic

History and Intake Form

Name: _____ **Date of Birth:** _____

Name I prefer to be called: _____

Past Medical History: (please check all that apply)

_____ Anxiety
_____ Arthritis
_____ Asthma
_____ Atrial fibrillation (irregular heartbeat)
_____ BPH
_____ Bone Marrow Transplantation
_____ Breast Cancer
_____ Colon Cancer
_____ COPD
_____ Coronary Artery Disease
_____ Depression
_____ Diabetes
_____ End Stage Renal Disease (Kidney)
_____ GERD
_____ Hearing Loss
_____ Hepatitis
_____ Hypertension (High Blood Pressure)
_____ HIV/AIDS
_____ High Cholesterol
_____ Hyperthyroidism (High)
_____ Hypothyroidism (Low)
_____ Leukemia
_____ Lung Cancer
_____ Lymphoma
_____ Prostate Cancer
_____ Radiation Treatment
_____ Seizures
_____ Stroke

Other _____

Past Surgical History: (please check all that apply)

_____ Heart: Coronary Artery Bypass
_____ Heart: PTCA (Angioplasty/Stent)
_____ Heart: Mechanical Valve Replacement
_____ Heart: Biological Valve Replacement
_____ Joint Replacement, Knee __Right ___Left
_____ Joint Replacement, Hip ___Right ___Left
_____ Ovaries Removed –Reason: _____
_____ Transplant Type: _____
_____ Uterine: Hysterectomy -Reason: _____

Other _____

Skin Disease History: (please check all that apply)

_____ Actinic Keratoses
_____ Basal Cell Skin Cancer
_____ Eczema
_____ Hay Fever/ Seasonal Allergies
_____ Melanoma _____(location/year)
_____ Atypical Moles
_____ Psoriasis
_____ Squamous Cell Skin Cancer

Other _____

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)?

_____

Any other family history: _____

TURN OVER TO COMPLETE

History and Intake Form

Name: _____ **Date of Birth:** _____

Medications: (Please enter all current medications)

_____

_____

_____

Allergies: (Please enter all medications you are allergic to)

_____

_____

Social History: Please check all that apply:

Illicit Drug Use: _____Drug Use _____IV Drug Use

Alcohol Use:
_____None _____less than 1 drink a day _____1-2 drinks per day _____3 or more per day

Smoking:
_____Never smoked _____ Former smoker _____Somedays _____Everyday

Please check all that currently apply:

Alerts:
_____ Allergy to adhesive
_____ Allergy to lidocaine
_____ Allergy to topical antibiotic ointments
_____ Artificial heart valve
_____ Artificial joints within the past two years
_____ Blood thinners
_____ Defibrillator
_____ MRSA
_____ Pacemaker
_____ Rapid heart beat with epinephrine
_____ Do you require antibiotics prior to a surgical procedure?
_____ Are you pregnant or currently trying to get pregnant?
_____ Allergy to Latex
_____ Allergy to Iodine

Review of Systems:
_____ Problems with bleeding
_____ Problems healing
_____ Abnormal scarring
_____ New or changing moles
_____ Swollen glands

Government regulations request the following:

Language: (if other than English) _____

Race: _____African American _____Asian _____Caucasian _____Other

Ethnicity: _____Hispanic or Latino _____Not Hispanic or Latino _____Unknown

Pharmacy Name : _____ **Phone #** (____)_____

Pharmacy Street: _____ **City:** _____

MANAGED CARE RESPONSIBILITY ACKNOWLEDGEMENT

I,_____understand that
(Patient or Guardian) (Please Print)

if my insurance requires any referral or authorizations, it is my responsibility to obtain these PRIOR TO EACH visit to D. Neal Mastruserio, M.D., LLC.

I am aware that if I do not have a referral at the time of my appointment, I will be responsible for the entire amount of my visit when services are rendered.

D. Neal Mastruserio, M.D., LLC is not responsible for obtaining managed care referrals; this is the patient's responsibility.

Date_____

Signature_____

Witness_____

D. NEAL MASTRUSERIO, M.D., LLC

CONSENT FOR RELEASE OF INFORMATION

Where are we allowed to attempt to contact you with test results?

HOME: YES NO (please circle)

If yes, what is your **home** phone number?_____

WORK: YES NO (please circle)

If yes, what is your **work** telephone number?_____

CELL PHONE: YES NO (please circle)

If yes, what is your **cell phone** number?_____

Please list family members to whom we are permitted to give test results:

Name and relationship:_____

Name and relationship:_____

Many times when calling we reach an **answering machine** or **voicemail**. Are we allowed to leave a detailed message with test results?

YES NO (please circle)

PRINTED Patient Name_____ Date_____

Patient SIGNATURE_____

Note: Test results of a sensitive nature will ONLY be given directly to the patient.

Acknowledgement of No-Show / Late Cancellation Policy

Here at the office of D. Neal Mastruserio, M.D., L.L.C., we have a no show and late cancellation policy. Failure to show up for your scheduled appointment or failure to call us with twenty four hours advance notice to cancel your appointment will result in a $25.00 charge for a regular scheduled appointment. There will be a $50.00 charge for any surgery appointment cancellation without notice.

By calling us in advance to reschedule or cancel your appointment, you give us the opportunity to schedule another person who may need to be seen more urgently.

_____

Patient Acknowledgement Signature