D. NEAL MASTRUSERIO, MD, 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# _____

Preferred appointment confirmation: email/text or phone

May we contact you for cosmetic sales & promotions: Y N

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 _____

Spouses' Name _____

By providing your email address, you authorize our office to contact you 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 _____

SSN _____

Insured's Date of Birth _____

Employer Name & Phone #_____

Subscriber ID# _____

Group # _____

Co-Pay or Coinsurance Amount _____

Secondary Insurance Information

Insurance Co. _____

Policy Holder _____

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, MD, 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., LLC

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 _____
___ __ 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? _____

D. NEAL MASTRUSERIO, M.D., LLC

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

Alerts: (Please check all that currently apply)

_____ Allergy to adhesive
__ __ Allergy to lidocaine
__ __ Allergy to topical antibiotic ointments
__ __ Artificial heart valve
__ __ Artificial joints within the past two years
_____ Blood thinners
__ __ Defribillator
_____ MRSA
_____ Pacemaker
_____ Rapid heartbeat with epineohrine
__ __ Allergy to latex
__ __ Allergy to Iodine

Review of Systems:

_____ Problems with bleeding
_____ Problems healing
__ __ Abnormal scarring
_____ New or challenging moles
__ __ Swollen glands

Pharmacy Name: _____**Phone#** _____

Pharmacy Street _____ City _____

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

If yes, what is your home phone number _____

WORK: _ _ Yes _ _ No

If yes, what is your work phone number? _____

CELLPHONE: _ _ Yes _ _ No

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

Printed Patient Name: _____ Date: _____

Patient Signature: _____

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

Managed Care & Insurance

Responsibility Acknowledgement

I, _____ understand that if my insurance requires

(Patient or Guardian) (Please Print)

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.

I understand that if I do not have my insurance card at the time of my visit, I may be asked to pay the entire amount of my visit when services are rendered.

I also understand that if there is a change in my insurance, I will notify D. Neal Mastruserio, M.D., LLC immediately, so that my claim will be submitted and paid in a timely manner.

Date _____

Signature _____

Witness _____

Acknowledgement of No-Show / Late Cancellation Policy

Here at the office of D. Neal Mastruserio, MD, LLC, we have a no show and a 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 charge for any surgery appointment cancellation without notice.**

By calling us or leaving a voicemail 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 Date