

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

Prof. 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 _____ Relationship _____
Address (if different) _____ Employer _____
City, State, Zip _____ Address _____
Phone# () _____ 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)

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

Other _____

Past Surgical History: (please check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Heart: Coronary Artery Bypass | <input type="checkbox"/> Joint Replacement, Knee ___ Right ___ Left |
| <input type="checkbox"/> Heart: PTCA (Angioplasty/Stent) | <input type="checkbox"/> Joint Replacement, Hip ___ Right ___ Left |
| <input type="checkbox"/> Heart: Mechanical Valve Replacement | <input type="checkbox"/> Ovaries Removed, Reason _____ |
| <input type="checkbox"/> Heart: Biological Valve Replacement | <input type="checkbox"/> Uterine: Hysterectomy, Reason _____ |

Other _____

Skin Disease History: (please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Actinic Keratoses | <input type="checkbox"/> Melanoma _____ location/year |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Atypical Moles |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Hay Fever/Seasonal Allergies | <input type="checkbox"/> 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
- _____ Defibrillator
- _____ MRSA
- _____ Pacemaker
- _____ Rapid heartbeat with epinephrine
- _____ 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 **\$50.00 charge** for a regular scheduled appointment. **There will be a \$75.00 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