Long Island Mohs Surgery

New Patient Information
Date:_____

Name:_____ Last four (4) digits of SSN: _____

Preferred Title: Ms. Miss Mrs. Mr. Dr. Other:_____ Sex: M F Date of Birth:_____

Street Address:_____ Apt #: _____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cellular #:_____

Work #:_____ Email:_____

Emergency Contact:_____ Relationship:_____

Home Phone:_____ Cellular #:_____

Who were you presently referred by:_____

Name of your Primary Medical Doctor:_____ Phone:_____

Dermatology History

How long has the skin cancer been present? _____ weeks months years

Has the lesion been treated previously? NO Yes: describe:_____

Have you had skin cancer previously? NO Yes: type: Melanoma Basal cell Squamous cell Other

Have you had Mohs surgery previously? NO YES

Have you ever had a complete skin exam? NO Yes: date:_____

Have you ever used tanning beds? NO YES Have you ever had a blistering sunburn? NO YES: number:_____

Have you ever had radiation to the skin? NO YES: describe:_____

Medical History

Are you allergic to any medications? NO YES: list:_____

List all medications you are currently taking (attach additional sheet if necessary):_____

_____

Do you take any of the following: Aspirin Baby Aspirin Ecotrin Coumadin/Warfarin Plavix/Clopidogrel
Heparin Lovenox Motrin Advil Ibuprofen Naprosyn Xarelto Pradaxa Eliquis None

Do you have a pacemaker?.....NO YES

Do you have a cardiac defibrillator?.....NO YES

Have you had a heart valve replacement?.....NO YES

Have you had any joint replacements?.....NO YES: Year_____

Have you had an adverse reaction to local anesthesia?.....NO YES NOT SURE

Have you ever fainted from blood or needles?.....NO YES

Do you drink alcohol?.....NO YES: Drinks per day_____

Do you smoke or use other tobacco products? NO YES: packs per day_____ Former Smoker? N / Y Quit:_____

Please circle if you have had any of the following medical problems:

Heart attack Stroke High blood pressure Irregular heart beat atrial fibrillation Diabetes Kidney disease HIV
Liver disease Hepatitis: type A B C Seizure Poor circulation Blood clot Bleeding or clotting disorder

Organ transplant If yes, describe:_____

Cancer other than skin cancer. If yes, describe:_____

Other medical conditions not listed:_____

(Women) Are you currently pregnant? NO YES NOT SURE Due Date:_____

Reviewed by: Physician: _____ Date:_____

New Patient Information

Long Island Mohs Surgery

Pharmacy Name:_____ Pharmacy Phone:_____

Pharmacy Address:_____

Name of Insured:_____ Date of Birth:_____

Employer:_____ Occupation:_____

Insurance Information (primary)

Insurance Company:_____

Address:_____

ID #:_____ Group #:_____

Primary card holder:_____ Date of Birth:_____

Name as it appears on insurance card:_____

Insurance Information (secondary)

Insurance Company:_____

Address:_____

ID #:_____ Group #:_____

Primary card holder:_____ Date of Birth:_____

Name as it appears on insurance card:_____

***if there is tertiary insurance information please inform the receptionist.**

I hereby request that payment of authorized Medicare, secondary or other insurance benefits be made on my behalf to Long Island Mohs Surgery for services rendered to me by their physicians. I authorized the release of medical information necessary to process such claims. I certify that the information I have reported with regard to my insurance coverage is correct. I understand that I am financially responsible for full payment of the service(s) in the event my insurance does not cover the entire charge(s).

Patient Signature:_____ Date:_____

Notice of Privacy Practices

I acknowledge the receipt of this office's **Notice of Privacy Practices.**

Patient Signature:_____ Date:_____

We look forward to meeting you and hope we can make this process as easy and painless as possible. Please call us at 516-745-0606 if you have any questions or concerns.

NOTICE OF PRIVACY PRACTICES

Long Island Mohs Surgery

WE ARE REQUIRED BY LAW TO PROVIDE THIS NOTICE DESCRIBING HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

If you have any questions about this notice please ask us.

With my permission, Long Island Mohs Surgery may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). "Protected health information" is information, including demographic information, that may identify me and that relates to my past, present or future physical or mental health care services.

I understand I have the right to review the full Notice of Privacy Practices prior to signing this consent and may request a printed copy. The Notice of Privacy Practices may be revised at any time and a revised Notice may be obtained by written request to the office.

Our physicians and staff may discuss, with other physicians or health care providers of their agents, any aspect of my care necessary to assist in carrying out treatment, payment, and healthcare operations (TPO).

Our physicians and staff may call my home or other designated locations and leave a message on voice mail or in person in reference to any aspect of my care that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including but not limited to laboratory results.

Our physicians and staff may mail to my home or other designated location, any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements.

If I have provided an email address, our physicians and staff may email any items that assist the practice in carrying out TPO to the electronic address I have provided.

Other uses and disclosures of my protected health information will be made only with my written authorization, unless otherwise permitted or required by law.

- I have the right to inspect and copy my PHI subject to a reasonable copying fee.
- I may submit a written request for amendment of my PHI. The request for amendment may be denied, but the request will be noted in any future disclosures.
- I may revoke or restrict this authorization in writing at any time. Such request must state the specific restrictions unless needed to provide emergency treatment. If I revoke my authorization, the office will no longer use or disclose protected health information for the reasons covered by my request. I understand the office cannot revoke disclosures already made with my prior authorization.
- I may request to receive confidential communications by alternative means.
- I have the right to request a printed copy of this or the full Notice of Privacy Practices.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Printed Name Relationship if other than patient

Meaningful Use Questionnaire

Patient Name:_____ **DOB:**_____

Approx. Height: _____

Approx. Weight:_____

Have you undergone a COLONOSCOPY in the last 9 years? **YES / NO**

Have you undergone a MAMMOGRAM screening in the last 2 years? **YES / NO**

Have you experienced any unusual changes due to your newly diagnosed lesion? (i.e. unintentional weight loss, shortness of breath, fever, chills, etc.) **YES / NO**

- **If YES, please list symptoms:** _____

Do you use a device to help assist you with walking? **YES / NO**

- **If NO, have you had any balance issues/trouble walking in the past year?** **YES / NO**