PLEASE NOTE:

IF YOUR INSURANCE REQUIRES A REFERRAL YOU WILL NEED TO CONTACT YOUR PCP PRIOR TO YOUR APPOINTMENT TO REQUEST ONE.

NEW PATIENT INFORMATION
PLEASE PRINT CLEARLY

Date: ____________________

Patient's Name:______________________________ Parent / Guardian: ______________________________
(if applicable)

Date of Birth:______________ Social Security #:________________ Sex: M/F Single/Married/Divorced/Widowed

Address:___________________________________ City:_______________________ State:__________ Zip:__________

Home Phone: ( ) _______________ Work Phone: ( ) ____________ Cell Phone: ( ) ________________

INSURANCE

Primary Care Physician: ______________________________ { Practice Name: ________________ Address/ Town or Ph# ________________

Name of Insurance:____________________ Employer: ____

Insurance Subscriber Name:____________________ Subscriber Date of Birth: ____________ Relationship to patient:________________

Subscriber Social Security Number: __________________ ID #________________ Group # __________

Secondary Insurance:___________________________ Name: ___________________ ID #:______________

☞**Were you referred by a medical provider? YES ❑ NO ❑** If ***YES***, Who referred you? ________________

Please read these items, check all the boxes, and sign below:

❑ I hereby authorize Drs Goldberg, Thyresson, Joselow, Finkle, Goldminz, Greenstein, Sisto, Fisher, Stewart, Sherman and Chartier or Mid-Level Providers: Lyell, PA-C, Hansen-Rodier, NP and Connolly, NP to examine and treat me for my dermatologic condition.

❑ The physicians and healthcare professionals of NEDA are committed to your health. As such, they are willing to perform a comprehensive (total body) skin screening. These screenings are meant to detect potential serious skin conditions (especially skin cancer), which you might not yet be aware of. If this is not the primary reason for your visit today, you can ask the provider or nurse if time will permit them to do this today, if there is not enough time please **make a future appointment for a complete screening before you leave today.** However, should you have any area of particular concern, please ask the doctor to look at it today.

❑ I understand that testing/procedures may be required to diagnose or treat my condition. I will have an opportunity to ask any questions before any test or procedure is performed. I do understand, however, that any procedure involves risks including, but not limited to, bleeding, infection and scarring. I am aware that a scar can result from any procedure and the type or severity of such scarring cannot always be predicted before the procedure. I understand that these tests (biopsies) need to be sent to the NEDA dermatopathology laboratory to be processed and to be read by a qualified dermatopathologist. I understand that under certain circumstances some tests may require additional processing which may incur further charges not collected at my initial visit.

❑ I authorize that the payment of insurance benefits be made on my behalf to Northeast Dermatology doctors Goldberg, Thyresson, Joselow, Finkle, Goldminz, Greenstein, Sisto, Fisher, Stewart , Sherman, Chartier and Brady (Dermatopathologist) or Mid-Level providers Ms. Lyell, PA-C, Ms. Hansen-Rodier, NP and Ms. Connolly, NP for any services furnished me by a NEDA healthcare professional. I further understand that prior to disbursing payment for services, my insurance company may require documentation from my medical record in order to approve payment.

❑ I agree to obtain and be responsible for any necessary referrals and paying required co-payments at the time of service. Patients with Private Insurance agree to assume full responsibility for the balance of services. Patients with no insurance assume full responsibility for balance at the time of service, unless prior arrangements have been made.

❑ I also understand that my insurance may not cover certain procedures and/or medications. (When necessary, your physician will help explain this, but cannot change the rules of your insurance policy.). I further understand that I may not receive a statement until my insurance company responds to the claim submitted by Northeast Dermatology. In the event that my insurance carrier determines that I was treated for a non-covered service or if I have a coinsurance or deductible, I agree to assume full responsibility for the balance not covered within 30 days of receipt of the 1st statement.

Signature ***(Must be 18 or older)***____ **Date:** ________________

Print Name: ____ Relationship to patient: _______________

Reason(s) for visit - include duration of time you have had the condition and any treatment you have received:

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___

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___

Any history of other dermatologic problems in the past:___

___

List your medical problems:

___

___

___

- ❑ Are you pregnant or breastfeeding
- ❑ MVP (Mitral Valve Prolapse)
- ❑ Pacemaker
- ❑ Do you take antibiotics at the dentist

List medications including vitamins, supplements, and holistic therapies:

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- ❑ Do you take aspirin
- ❑ Do you take coumadin

List any known or questioned allergies:

___

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___

Do any family members have skin problems?:____

What is your occupation?:____

Do you smoke?:________Amount per day:________

Do you consume alcohol?:_______Amount per day:________

Have you been exposed to any contagious illnesses or traveled abroad?:_______________

Do you have any of the following symptoms?:

Pulmonary:	Asthma	Yes____No ____	Renal:	Blood in urine	Yes____No ____
	Shortness of breath	Yes____No ____		Infection	Yes____No ____
	Pneumonia	Yes____No ____	Neuro:	Headaches	Yes____No ____
Cardiovascular:	Chest pain	Yes____No ____		Fainting	Yes____No ____
	Palpitation	Yes____No ____		Seizures	Yes____No ____
	Shortness of breath	Yes____No ____	Rheumatology:	Joint problems	Yes____No ____
GI:	Liver problems	Yes____No ____		Pain	Yes____No ____
	Diarrhea	Yes____No ____	General :	Fever	Yes____No ____
	Jaundice	Yes____No ____		Chills	Yes____No ____

NEDA provides a full line of aesthetic and cosmetic products, aesthetic services and cosmetic procedures. Are you interested in learning more about NEDA services?

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Physician Signature:___________________________________ **Date:**___________________________________

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Northeast Dermatology Associates may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Northeast Dermatology Associates' **Notice of Privacy Practices** for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Northeast Dermatology Associates reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Northeast Dermatology Associates' Chief Privacy Officer at [*401 Andover Street, Suite 101 ~ North Andover, MA 01845*].

With my consent, Northeast Dermatology Associates may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Northeast Dermatology Associates 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 as long as they are marked Personal and Confidential.

With my consent, Northeast Dermatology Associates may e-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. I have the right to request that Northeast Dermatology Associates restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Northeast Dermatology Associates use and disclosure of my PHI to carry out TPO and I verify that I have read and accepted Northeast Dermatology's Notice of Privacy Polices.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Northeast Dermatology Associates may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

______________________________ ________________
Patient's Name Date

____
Print Name of Patient or Legal Guardian