HEALTH QUESTIONNAIRE

To be completed by patient - please print

DATE

NAME

REASON FOR VISIT

FAMILY HISTORY

FOLLOW THE LINES ACROSS THE PAGE AND MARK THE APPROPRIATE BOX

	ALIVE & WELL	DECEASED	CAUSE OF DEATH (AGE)	SKIN CANCER	MELANOMA	MANY MOLES	HIGH BLOOD PRESSURE	HEART DISEASE	PSORIASIS	DIABETES	CANCER	ASTHMA	HAYFEVER	ARTHRITIS	ECZEMA
FATHER															
MOTHER															
BROS / SIS															
MOTHER'S RELATIVES															
FATHER'S RELATIVES															

HOSPITAL ADMISSIONS

Indicate the year you were admitted and the reason. Do Not include normal pregnancies.

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

MEDICATIONS

LIST ALL MEDICATIONS THAT YOU ARE NOW TAKING. INCLUDE OVER THE COUNTER RX & HERBAL MEDS. (ALTERNATIVE MEDS)

NAME	STRENGTH	HOW OFTEN	NAME	STRENGTH	HOW OFTEN

DRUG ALLERGIES

☐ NONE ☐ YES

MEDICAL HISTORY

Mark (c) for cuirrent problems. Check (3) box indicate age when you had any of the following systoms or

Current or past problems with: (Review of Systems)

	YES	NO	(If yes, explain)
Eyes (Glaucoma / Cataracts)	☐	☐	______
Ears/Nose/Throat/Mouth	☐	☐	______
Heart (Murmur/Heart Attack)	☐	☐	______
High Blood Pressure	☐	☐	______
Pacemaker	☐	☐	______
Lungs	☐	☐	______
Stomach/bowel (ulcers, heart burn, colitis)	☐	☐	______
Liver (hepatitis)	☐	☐	______
Kidneys	☐	☐	______
Arthritis/muscles/joints (Gout)	☐	☐	______
Skin (Psoriosis, Exzema)	☐	☐	______
Headaches / Seizures	☐	☐	______
Psychological disorder	☐	☐	______
Thyroid / Diabetes	☐	☐	______
Blood/bleeding discrder (anemic)	☐	☐	______
Allergic (hayfever / asthma)	☐	☐	______
X-ray Therapy	☐	☐	______
Cancer	☐	☐	______
Autoimmune Disease	☐	☐	______

FEMALES

ARE YOUR PERIODS REGULAR: ☐ YES ☐ NO
BIRTH CONTROL PILL ☐ YES ☐ NO
BIRTH CONTROL PILL (BRAND) ______
MENOPAUSAL ☐ YES ☐ NO
ARE YOU POST MENOPAUSAL ☐ YES ☐ NO
ARE YOU PREGNANT ☐ YES ☐ NO
Are You PLANNING To Get PREGNANT ☐ YES ☐ NO

SKIN PROBLEMS

1. DID YOU EVER HAVE SKIN CANCER? ☐ YES ☐ NO
2. DID YOU EVER HAVE MELANOMA? ☐ YES ☐ NO
3. DO YOU FORM KELOIDS AFTER SURGERY? ☐ YES ☐ NO

SOCIAL HISTORY

ALCOHOL - # OF GLASSES PER WEEK ______
SMOKING - # OF CIGS PER WEEK ______
HOW MANY YEARS SMOKING ______
COFFEE / TEA - # OF CUPS PER DAY ______

Huntington Dermatology & Cosmetic Associates, PC

· Phyllis J· Smith, MD, FAAD Wil D· Tutrone, MD Collene Greco, ANP

200 West Carver Street, Suite 2, Huntington, NY 11743

Phone: (631) 424-3376 Fax: (631) 424-0199

PATIENT UPDATE

Date: ______________________________ Date of Birth_______

Name: ______________________________

Address: ______________________________

Occupation: ______________________________ SS#______________

Numbers: Home ______________________________

Cell ______________________________

Work ______________________________

E-Mail: ______________________________

Insurance Company: ______________________________ ID#______________

Who holds insurance: ______________________________ DOB______________

Do you need a referral
For a specialist: Yes____No____Do you have one for today's visit_____

Should biopsy be forwarded
To any of your doctors Yes____No____Doctors' name and fax_____________

Pharmacy & Phone Number ______________________________

If you are not home, who may
we speak with regarding your
care: ______________________________

Financial Policy

WELCOME TO OUR PRACTICE!

We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. Thus, in order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy.

Unless other arrangements have been made in advance by either yourself or your health coverage carrier, full payment is due at the time of service.

YOUR INSURANCE

We have prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with whom we participate, and will only require you to pay the authorized copayment at the time of service. It is the policy of our office to collect the copayment when you arrive for your appointment. All copayments not paid at the time of service will be billed an additional $5 to cover administrative costs.

Managed care and HMO insurance companies have many rules and regulations. Because we participate in many insurance plans, we can no longer be responsible for ensuring your compliance with your insurance company rules. However, to the extent possible, we will attempt to assist you in your efforts to understand and comply with your insurance company's requirements.

If you are in a Managed Care Plan or HMO, please make sure you are aware of the following information:

Is a referral from your primary care physician needed?
Does your referral cover more than this visit?
When does your referral expire?
What clinical lab is contracted with your insurance company?

In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. Biopsies and procedures are frequently not covered in the same visit. Please contact your insurance company directly for the answer to these and other questions. **You are ultimately responsible to know your own insurance policy and their limitations.** If you have any questions, please discuss them with our office manager.

Signature ______________________________ Date____________________________

Please print name of patient ____

HIPAA Consent Form and Acknowledgement for the Notice of Privacy Practices

Print Patient Name____________________________ Patient Date of Birth_______________

Phone Number______________________________ Email____________________________

As a result of HIPAA, enforced by the US Department of Health and Human Services office of Civic Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices or in accordance with your wishes as stated below.

This consent authorizes Huntington Dermatology & Cosmetic Associates to send/give my medical information as noted:

Leave voice mail recording including my Personal Health Information on my home telephone ___Yes ___No

Leave voicemail recording including my Personal Health Information on my cell phone: ___Yes ___No

Leave voicemail recording including my Personal Health Information on my business phone ___Yes ___No

Leave voicemail regarding appointment changes, cancellations or conformations on my home. Cell phone or business number ___Yes ___No

Permit the individual stated below (Personal Representative) to receive prescriptions And/or test results ___Yes ___No

Speak to a family member of my choosing (Personal Representative) regarding my Personal Health Information ___Yes ___No

Biopsy forwarded to your primary care or referring doctor ___Yes ___No
Name of doctor and fax____

Name of Personal Representative (print)____

Relationship to Patient (print)____

On this date_________________, I received and reviewed Huntington Dermatology & Cosmetic Associates' Notice of Privacy Practices, which describes how my medical information may be used and disclosed.. I understand that my medical information may be maintained in an electronic health record and/or transmitted securely over the internet or by fax.

I acknowledge that by giving consent to Huntington Dermatology, any or all of the physicians and/or staff that are involved in my care may access these records.

*If there is any physician that requires restriction, please document here____________________

I had an opportunity to raise questions regarding this policy and all my questions, if any, have been answered___Yes ___No

The authorization above will remain in effect until such time as I notify Huntington Dermatology & Cosmetic Associates.

____ ____
Patient or Parent/Guardian/personal Representative Date

____ ____
Print Full Name Relationship to Patient

Huntington Dermatology & Cosmetic Associates P.C.
Phyllis J. Smith, MD, FAAD   Wendy Lou, MD, FAAD   Collene Greco, ANP   Jill-Marie Brown, ANP
200 West Carver St. Huntington NY 11743 Phone: (631) 424-3376 Fax: (631) 424-0199

NO SHOW/MISSED APPOINTMENT POLICY

We, at Huntington Dermatology & Cosmetic Associates, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the following number: 631-424-3376

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

If you do not give us 24 hour notice, or if you do not show up for a scheduled appointment, you will be charged a $25 fee for a missed office visit or $50 for a missed procedure appointment.

I have read and understand Huntington Dermatology & Cosmetic Associates' No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify the office if I can not keep my scheduled appointment.

_______________________________________ ______________

Patient Name Date

_______________________________________ ______________

Patient Signature or Parent/Guardian if minor Relationship to Patient

COSMETIC INTEREST QUESTIONNAIRE

Huntington Dermatology & Cosmetic Associates is constantly striving to offer you the safest, most advanced procedures for facial and overall physical improvement. Please check any of the following cosmetic treatments you would like to receive more information on.

- ☐ Fine lines and wrinkles
- ☐ Facial Fillers
- ☐ Eyelashes; Longer, Fuller, Darker
- ☐ MicroDermabrasion
- ☐ Overall Skin Rejuvenation/Skin care advice
- ☐ Medical skin care products/Retin-A or Renova
- ☐ Treatment for spider veins/leg veins/facial veins
- ☐ Laser skin resurfacing
- ☐ Laser treatments with no down time
- ☐ Laser hair removal
- ☐ Age spots/facial pigmentation problems
- ☐ OTHER ____

Please answer the question below on a scale of 1 to 5 by circling the appropriate number:

» When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of wrinkles on my face. (1 – Not Concerned → 5 – Very Concerned)

1 2 3 4 5

How did you hear about our practice?

- ☐ A friend or family member (please name) ____________________
- ☐ Yellow pages
- ☐ Physician referral (please name) ____________________
- ☐ Internet
- ☐ An article or advertisement in ____________________
- ☐ Other ____________________

Would you like to receive announcements on special discounts, new products or procedures?

☐ YES ☐ NO

If YES, what address can we send it to? ____

Would you like to receive this information via an email address?

☐ YES ☐ NO

If YES, please list your email address (name@example.com) ____________________

SIGNITURE ____________________________ **DATE** ________________

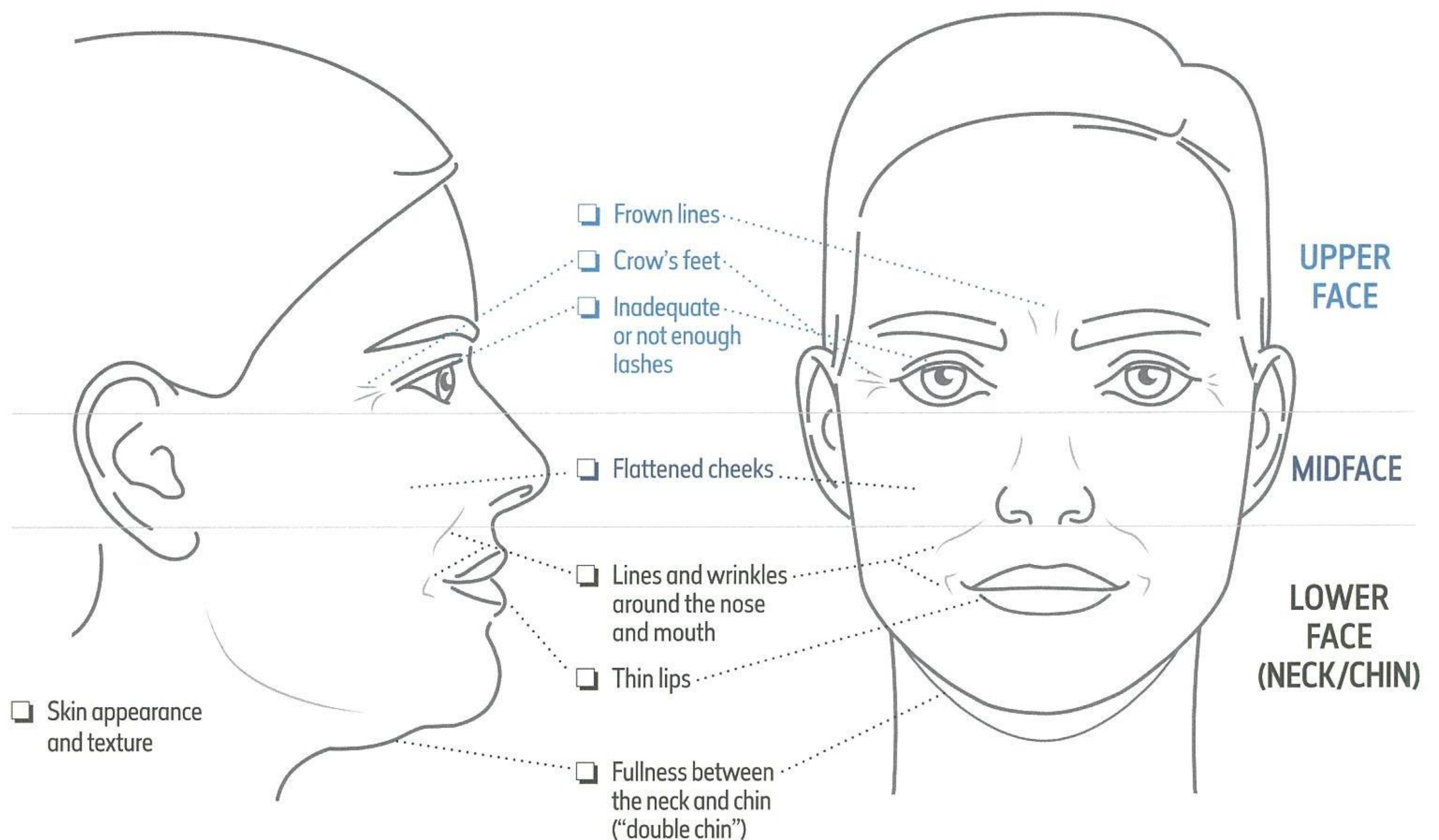
SELF-ASSESSMENT

NAME: ______________________ DATE OF BIRTH: ______________ DATE: ______________

What brings you in today? ______________________________

Select which areas of the face concern you on the diagram below.

By sharing how you see yourself, we can best evaluate your aesthetic goals and select an appropriate treatment for you.



Please complete and return this form to the front office before your consultation.

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Huntington Dermatology & Cosmetic Associates, PC

Phyllis J. Smith, MD, FAAD   Wendy Lou, MD   Collene Greco, ANP   Jill Marie Brown, ANP

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To our Patients:

As you know if you have ever checked into a hotel, you are asked for your credit card at the time you check in. This is an advantage for both you and the hotel, since it makes checkout easier and more efficient. At Huntington Dermatology & Cosmetic Associates,PC we are implementing a similar policy.

You will be asked for your credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us regarding the amount you are responsible for.

At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out.

This is no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays due at the time of your visit will still be collected that day.

Sincerely,

Phyllis J. Smith, MD
Wendy Lou, MD
Collene Greco, ANP
Jill Marie Brown, ANP

I authorize Huntington Dermatology & Cosmetic Associates to charge outstanding balances on my account to the following credit card.

Visa ☐   Mastercard ☐   American Express ☐   Discover ☐

Account Number: ____________________ Expiration Date: __________
Name (As printed on Card): ____________________
Signature: ____________________Date: __________