HOW DID YOU HEAR ABOUT US? Circle one:

1. Friends/family
2. Previous patient
3. Medical office/Doctor referral (specify name) :_____
4. Walk-in
5. Online/Google
6. Insurance
7. Other (specify) :_____

PATIENT'S NAME _____(FIRST) _____(LAST)

Date of Birth _____ (mm/dd/yyyy)

Social Security Number _____/_____/_____

Gender __Male __Female __Other

Marital Status: Single Married Divorced Widow Other: _____

RACE:

___White __Black or African American __American Indian or Alaska-Native

___Native-Hawaiian or other Pacific Islander ___Asian ___ Other

ETHNICITY: __Hispanic or Latino __Non-Hispanic or Latino

PHONE NUMBERS

Home_____ Cell _____ Work

Preferred phone: __ Home __ Cell __ Work

Is it OK to leave a detailed message? __YES or __NO

Email: _____

Patient's Address: _____

_____

PHARMACY INFORMATION: Name: _____

Address: _____

Phone: _____

IV Drug Use: Y___ N_____ **IV Drug Use Within Past 12 months**: Y___ N_____

Alcohol Use: Y___ N_____

Men: 5 or more drinks a day _____

Women: 4or more drinks a day _____

Do you give us consent to speak to(emergency contact)? Y__N__

If yes, Name_____(Relationship)_____. Tel_____

PAST MEDICAL HISTORY (CIRCLE ALL THAT APPLY TO YOU)
Stents
Organ Transplant
Heart Murmur
Mitrovalve Prolapse
Anxiety
Hearing Loss
Arthritis
Hepatitis
Asthma
Hypertension
Atrial Fibrillation (Irregular heartbeat)
HIV/Aids
BPH (benign enlarged prostate)
Hypercholesterolemia (high cholesterol)
Bone Marrow Transplantation
Hyperthyroidism
Breast Cancer
Hypothyroidism
Colon Cancer
Leukemia
COPD
Prostate Cancer
Coronary Artery Disease
Radiation Treatment
Depression
Seizures
Diabetes
Stroke
End Stage Renal Disease
GERD
Other _____

SURGICAL HISTORY (list all surgeries)

_____

_____

SKIN DISEASE HISTORY (CIRCLE ALL THAT APPLY TO YOU)
Acne
Actinic Keratosis
Skin cancer: Basal Cell Carcinoma _____; Squamous Cell Carcinoma _____; Melanoma____
Blistering Sunburn
Precancerous Moles
Psoriasis
Eczema
Other _____

Do you wear Sunscreen? If yes, what SPF?_____ Do you tan in tanning salon? Y__N__

FAMILY HISTORY OF MELANOMA _Yes or ___No

If yes, which relative __Mother __Father __Sister __Brother __Daughter __Son
__Uncle __Aunt __Nephew __Niece __Grandmother __Grandfather

MEDICATIONS (Please list or give to front desk)

_____
_____
_____

ALLERGIES TO MEDICATIONS? YES_____N0_____
If "Yes", what medications

_____
_____

FEMALES ONLY Last menstrual period (LMP)_____ Menopausal __Yes or __No

SMOKING HISTORY

Current every day smoker / Former smoker /Nonsmoker (Circle one)

Please mark Yes or No if you have any of the following
Pacemaker __YES __NO
Defibrillator __YES __NO
Premedication prior to procedure __YES __NO; *IF YES, NAME*: _____
Allergy to adhesive __YES __NO
Blood thinners __YES __NO
Pregnancy or planning a pregnancy __YES __NO __N/A
Allergy to lidocaine __YES __NO
Have you ever had dental anesthesia Novocain __YES __NO; Epinephrine __YES __NO
Problems with bleeding __YES __NO
Artificial joints within past two years __YES __NO
Artificial heart valve __YES __NO

Are you your own Power of Attorney (POA)? __ YES __ NO

REASON FOR YOUR VISIT TODAY

_____

Do you give consent to electronically update medication list from your pharmacy? __YES __NO
Do you give consent to update your patient portal? __YES __NO
Primary Care Physician (PCP): Name _____Tel:_____

QUALITY DERMATOLOGY

RENATA FLAKS, DNP

707 MAIN STREET
TOMS RIVER, NJ 08753
TEL: 732.244.2666
FAX: 732.286.7040

NO SHOW/CANCEL POLICY

All no-shows and patients who cancel their appointments without 24 hour notice will be charged a fee of $150

(Please initial)_____

Our office will call you to confirm one business day before your appointment time. Please be aware that your APPOINTMENT will be cancelled if it is NOT CONFIRMED by you

(Please initial)_____

Sign_____

Date_____/_____/_____

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for, Renata Flaks, DNP to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations {TPO}. ***(Renata Flaks, DNP's Notice of Privacy Practices provides 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. The practice reserves the right to revise its Notice of Privacy Practices at Renata Flaks, DNP's anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Renata Flaks, DNP. Privacy Officer at

Renata Flaks, DNP
707 Main Street
Toms River, NJ
08753

With this consent, Renata Flaks, DNP may call my home, cell or other phone number listed on my chart 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 anything pertaining to my medical care, including laboratory test results among others.

With this consent, Renata Flaks, DNP may mail to my home or other alternative locations listed on my chart any item 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 this consent, Renata Flaks, DNP may e-mail me any items assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Renata Flaks, DNP 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 Renata Flaks, DNP's use and disclosure of my PHI to carry out my TPO.***

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, or later revoke it, Renata Flaks, DNP may decline to provide treatment to me.

Signature of Patient or Legal Guardian _____

Print Name of Patient or Legal Guardian _____

Date ____/_____/_____

Quality Dermatology, LLC

Renata Flaks, DNP

707 Main Street

Toms River, NJ 08753

(732) 244-2666

Patient or POA:_____

Please be advised, although your insurance company has authorized services, this is not a guarantee of payment. If your insurance company denies those services, you will be responsible for payment. (Please initial)_____

I have been advised that if Quality Dermatology does not accept my secondary insurance I will be responsible for any remaining balance after my primary insurance.

(Please initial)_____

It is my responsibility to obtain a referral if it is required by my insurance. If I fail to provide a valid referral at the time of service and my insurance denies my bills for lacking referral/authorization, I will be responsible for payment in full to Quality Dermatology.

(Please initial)_____

I have been advised that Quality Dermatology sends all specimens to labs of practice choice. If patient's insurance is associated with specific lab(s), it is patient's responsibility to inform Quality Dermatology of their lab(s) before the appointment.

(Please initial)_____

Patient or POA Signature_____

Date ___/_____/_____

Dr. Renata Flaks, DNP
Quality Dermatology
707 Main Street, Toms River, New Jersey 08753
Tel: (732) 244-2666
Fax: (732) 286-7040

NON-COVERED, MEDICALLY UNNECESSARY SERVICES

Insurance, or Medicare, will not pay for services that are being performed for COSMETIC purposes. The removal of benign lesions that are not suspected of being dangerous fall into this category.
These include:

Benign moles
Seborrheic keratosis
Brown spots
Skin tags
Milium
Comedone extraction and blackhead removal
Hemangiomas

Consultation for Microneedling, Chemical Peels, PRP for hair loss, Fillers, and Botox requires a separate COSMETIC office visit/appointment and non-refundable fee of $150, which will be applied towards the treatment (only 1 rescheduled appointment is allowed within 30 days from the date of payment).

I am aware that the above elective procedures are for cosmetic purposes, and are therefore non-reimbursable by Insurance, or under Medicare and require an out-of-pocket fee.

I understand and agree to the above.

Print name _____

Signature _____

Date _____//_____//_____

QUALITY MEASUREMENTS
For patients 65 and older

Name of patient _____

Have you received a **pneumonia vaccination**? Y___ N___

If not, was the **reason medical**: Y___ N___
State the medical reason: _____

Do you have **living will**? Y___ N___

Do Not Intubate ___

Do Not Resuscitate (DNR)____

Full Cardio Pulmonary Resuscitation (CPR)___

Do you have a **health care proxy** if you are unable to make your own medical decisions? Y___ N___

If yes, name_____, tel _____

IV Drug Use: Y___ N___ **Drug Use Within Past 12 months**: Y___ N___

Alcohol Use: Y___ N____

Men: 5 or more drinks a day _____

Women: 4or more drinks a day _____

NAME

DATE

HEIGHT

WEIGHT

EMAIL