FEINSTEIN
DERMATOLOGY
& COSMETIC SURGERY

6140 W. Atlantic Avenue * Delray Beach, FL 33484
Tel: (561) 498-4407 * (888) 357-DERM * Fax: (561) 498-4480
www.feinsteindermatology.com

Today's Date:_____ **Reason for Visit:** _____
Patient Name: (Last) _____ (First) _____(Middle) _____
Permanent Address (Local): Street _____
City/State/Zip: _____
Secondary (Out of State) Address: _____
City/State/Zip: _____

Pharmacy Name/Phone: _____ **City:** _____ **Cross Street:** _____

Home Phone: _____ **Work Phone:** _____**Cell:** _____
Social Security #: _____ **Date of Birth:** _____ **Approximate Weight:** _____
Email: _____

Sex: **M** **F** **Marital Status:** (Circle) Single Married Divorced Widowed Separated

Race: _____ **Ethnicity:** _____ **Language Spoken:** _____
Emergency Contact: _____ **Phone Number:** _____
Relationship to Patient: _____
Parent/Guardian of Patient: _____**Phone Number:** _____
Primary Physician: _____ **Phone Number:** _____
Patient Occupation: _____ **Referred By:** _____

What skin care products have you used or are currently using: _____
_____
Would you like to discuss skin care products with Dr. Feinstein, Dr. Nolan and/or the assistants: YES NO

Insurance Coverage-Primary: _____

Name of Policy Holder (Insured): _____

Policy Holder Date of Birth: _____ Social Security Number: _____

Relationship to Policy Holder: _____

Insurance Coverage-Secondary: _____

Policy Number _____

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MEDICAL HISTORY FORM

Patient Name: _____ DOB: _____ Date: _____

ALLERGIES: _____

_____

MEDICAL HISTORY

Please list current or prior:

_____

_____

_____

_____

MEDICATIONS

Please list current medications:

_____

_____

_____

_____

_____

Medication List Attached: Yes No

Pharmacy: _____

Phone #: _____

HOSPITALIZATIONS

Please list your previous hospitalizations:

_____

_____

_____

SURGICAL HISTORY

Please list previous surgeries:

_____

_____

_____

DERMATOLOGIC HISTORY

Please check if ***YOU*** have a history:

Melanoma	Yes	No
Squamous Cell Carcinoma	Yes	No
Basal Cell Carcinoma	Yes	No
Skin Cancer, Uncertain Type	Yes	No
Dysplastic (Atypical) Moles	Yes	No
Actinic Keratosis (Pre-Cancer)	Yes	No
Eczema/Psoriasis	Yes	No
Acne/Rosacea	Yes	No

Other _____

Year/Location if known: _____

Treatment: _____

_____

FAMILY HISTORY

Melanoma	Yes	No
Squamous Cell Carcinoma	Yes	No
Basal Cell Carcinoma	Yes	No
Skin Cancer, Uncertain Type	Yes	No

Other _____

SOCIAL HISTORY (Please Circle)

Alcohol: None Yes: Amount _____

Tobacco: None Yes: Amount _____

Drug Use: None Yes: Amount _____

Lifetime Sun Exposure: Mild Moderate Heavy

History of Blistering Sunburn: Yes No

When in the sun, do you: Burn Tan Burn then tan

Sunscreen use: Always Occasionally Rarely

Ever use a tanning bed: No Yes, how many times? _____

PATIENT SIGNATURE: _____

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REVIEW OF SYSTEMS

Patient Name:_____ DOB: _____ DATE: _____
Please indicate below if you currently have or have had the following:

Systemic

HIV or AIDS	Yes	No
History of Rheumatic Fever	Yes	No
Weight Loss/Gain	Yes	No
Diabetes	Yes	No
High Cholesterol	Yes	No
Hepatitis (Type: A, B, C)	Yes	No
High Blood Pressure	Yes	No
Herpes (Oral/Genital)	Yes	No
Stroke	Yes	No
Epilepsy or Seizures	Yes	No

Eyes

Cataracts	Yes	No
Glaucoma	Yes	No

Any Complaints: If yes: _____
_____

Ear, Nose, Mouth

Any Complaints: If yes: _____
_____

Cardiovascular

Swelling of Legs	Yes	No
Heart Attack	Yes	No
Pacemaker or Defibrillator	Yes	No

Respiratory

Asthma	Yes	No
Shortness of Breath	Yes	No
Hay fever, Seasonal Allergies	Yes	No

Gastrointestinal

Any Complaints: If yes: _____
_____

Musculoskeletal

Muscle or Joint Pain	Yes	No
Arthritis	Yes	No
Artificial Joints	Yes	No

Female Issues

Pregnant/Breastfeeding	Yes	No
Breast Lumps or Lesions	Yes	No

Male Issues

Testicular Lesions	Yes	No

Neurological

Dizziness	Yes	No
Numbness	Yes	No
Headaches	Yes	No
Weakness	Yes	No

Psychiatric

Depression	Yes	No
Anxiety	Yes	No

Urinary

Any Complaints: If yes: _____
_____

Dermatology

Skin Allergies	Yes	No
Bruises Easily	Yes	No
Hair or Nail Changes	Yes	No
New or Changing Moles	Yes	No
Dry or Sensitive Skin	Yes	No
Rashes	Yes	No
Bleeds Easily/Excessively	Yes	No
Keloids (scars) after Surgery	Yes	No
Problems Healing	Yes	No
History of Skin Cancer	Yes	No

PATIENT SIGNATURE: _____

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SOCIAL HISTORY QUESTIONNAIRE (For Quality Improvement - Required by CMS)

We thank you for your time!

Name:_____ Date:_____

1. **Do you have an Advance Care Plan/Advance Directive (Living Will) in place with a named surrogate decision maker?**
   ☐ Yes (SDM) ☐ No (NSDM)

2. **Are you a:** ☐ Never Smoker ☐ Former Smoker ☐ Current Smoker

3. **If 'Former Smoker': How long has it been since you last smoked?**

   ☐ 1-3 Months ☐ <1 Month ☐ 3-6 Months ☐ 6-12 Months

   ☐ 1-5 Years ☐ 5-10 Years ☐ >10 Years

4. **If 'Current Smoker':**

   a. How often do you smoke cigarettes?

      ☐ Every day ☐ Some days, but not every day

   b. How many cigarettes a day do you smoke?

      ☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more

   c. How soon after you wake up do you smoke your first cigarette?

      ☐ Within 5 minutes ☐ 6-30 minutes ☐ 31-60 min ☐ after 60 min

   d. Are you interested in quitting?

      ☐ Ready to quit ☐ Thinking about quitting ☐ Not ready to quit

5. **Have you had a drink containing alcohol in the past year?** ☐ Yes ☐ No

   a. If "Yes": How often did you have a drink containing alcohol in the past year?

      ☐ Never ☐ Monthly or less ☐ 2-4 month ☐ 2-3 week ☐ 4+ week

   b. If "Yes": How many drinks did you have on a typical day when you were drinking the past year?

      ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more

   c. If "Yes": How often did you have 6 or more drinks on one occasion in the past year?

      ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily/Almost Daily

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LIFETIME AUTHORIZATIONS

For the release of medical records: I authorize the release of any medical information required by my insurance carrier(s) needed for this or any related claim. I authorize any holder and the health care financing administration or its intermediaries or carriers any information needed for this insurance claim or any related medical claim.

For the payment of benefits to the physician/provider: I, understand that Feinstein Dermatology & Cosmetic Surgery has agreed to accept Medicare and/or Health Insurance for payment of my bills by my signature below. I acknowledge and understand that I am fully responsible at the time of services for any yearly deductible, co-pay and/or coinsurance balance due which is to be paid by me to Feinstein Dermatology & Cosmetic Surgery. I further understand that should payment be denied due to **"**PRE-EXISITING ILLNESS", NON-COVERED OR TERMINATION OF COVERAGE, I will be responsible for payment of such fees within 10 days of such notification. I understand that I will be billed for the remaining unpaid balance and I understand that I am financially responsible for any charges not covered.

Self Pay Financial Policy: I understand, as a self-pay patient, that I am responsible to pay the bill at the time the services are rendered. These charges will include but not limited to consultation, laboratory fees, surgery fees and any other fees associated with my appointment.

Appointment Cancellation: Please be courteous and call Feinstein Dermatology and Cosmetic Surgery promptly if you are unable to attend an appointment. If it is necessary to cancel your scheduled appointment, we require that you give at least ***24 hours'*** notice. Less than 24 hours' notice doesn't allow us to offer an appointment to another patient in need. There will be a ***$50.00*** charge if you fail to show up for your scheduled appointment or cancel with less than 24 hours' notice. Unavoidable circumstances may warrant special consideration, but please note that the above charges will apply to most cancellations. Thank you for understanding the importance of keeping your appointment.

METHOD OF PAYMENT

Payment is required at the time services are rendered. Feinstein Dermatology & Cosmetic Surgery is a participating provider with Medicare Advantage, PPO and HMO insurance plans. Please check with our receptionist to see if we participate with your health insurance plan. All medical claims will be filed automatically by our office. Please present your insurance card(s) to our receptionist for photocopying and benefit eligibility verification.

The information requested on this form must be completed in its entirety and will remain confidential. Your selection of Feinstein Dermatology & Cosmetic Surgery for your skin care is greatly appreciated. If you have any questions or require assistance, please do not hesitate to ask one of our staff members.

SIGNATURE: _____ PRINTED NAME: _____ DATE: _____

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OPTIONAL COSMETIC PROCEDURES INTEREST

(Please write your name and date even if you are not interested)

PATIENT NAME: _____ **DATE:** _____

AREA(S) OF CONCERN

- ☐ Brown Spots
- ☐ Age Spots
- ☐ Sun Damage
- ☐ Wrinkles
- ☐ Fine Lines
- ☐ Deep Lines
- ☐ Acne
- ☐ Acne Scars
- ☐ Hyperpigmentation
- ☐ Rosacea
- ☐ Sagging Eyelids
- ☐ Loose Skin
- ☐ Earlobe Repair
- ☐ Unwanted Hair
- ☐ Leg Veins
- ☐ Facial Veins
- ☐ Other

INTERESTS

- ☐ LASER PROCEDURES
- ☐ Laser Hair Removal
- ☐ BBL
- ☐ Erbium
- ☐ Thermascan
- ☐ Skin Tyte
- ☐ Facial Rejuvenation
- ☐ Laser Peels
- ☐ SPECIFIC BODY PARTS
- ☐ Face
- ☐ Neck
- ☐ Chest
- ☐ Arms
- ☐ Hands
- ☐ Abdomen
- ☐ Legs
- ☐ Other

- ☐ DERMAL FILLERS
- ☐ Botox
- ☐ Juvederm
- ☐ Restylane
- ☐ Perlane
- ☐ Volbella
- ☐ Vollure
- ☐ Voluma
- ☐ OTHER TREATMENTS
- ☐ Kybella
- ☐ Earlobe Repair
- ☐ Sclerotherapy
- ☐ Chemical Peels
- ☐ Other

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Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, _____ (Print Name) have been given the opportunity to read a copy of Feinstein Dermatology & Cosmetic Surgery's Notice of Patient Privacy Practices.

_____ _____

Signature of Patient **Date**

1. May we leave appointment information on your answering machine or cell phone?

YES NO

(Circle One)

Please be advised that we are unable to leave lab results on an answering machine or cell phone.

2. Do you give our office permission to discuss your medical information with family members or other individuals (including spouse)?

YES NO

(Circle One)

If yes, please provide their names & phone numbers below.

Name: _____ Relationship: _____
Phone # (day): _____ Phone (evening): _____

Name: _____ Relationship: _____
Phone # (day): _____ Phone (evening): _____