HWS RMS AJG SLB

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT DATA

Last Name _____ First Name _____ M.I. ____

Birthdate Mo _____ Day _____ Yr _____ Age _____ Sex: M ☐ F ☐ Marital Status: M ☐ S ☐

Address _____

City _____ State _____ Zip _____

Occupation _____ Employer _____

Employer Address _____

City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____

Cell Phone (____) _____ Social Security No. _____-_____-_____

Email _____

ADDITIONAL DATA

Name of Spouse (if married) or Parent (if Minor) _____

Birthdate Mo _____ Day _____ Yr _____ Employer _____

Employer Address _____

City _____ State _____ Zip _____

Employer Phone (____) _____

Social Security No. _____-_____-_____ Driver's License # _____

In the Case of an Emergency, Contact _____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____

Primary Physician _____

Phone (____) _____

How did you learn about our office? _____

Referred by: Dr. _____

Phone (____) _____

Patient's Signature _____ Date _____

Insured's Signature _____ Date _____

INSURANCE INFORMATION ON BACK OF FORM

INSURANCE DATA

(Primary) Relationship to Patient _____

Name of Company _____

Insured's Name _____ Date of Birth _____

Group # _____

Policy ID # _____

(Secondary) Relationship to Patient _____

Name of Company _____

Insured's Name _____ Date of Birth _____

Group # _____

Policy ID # _____

Our office will file insurance for you as a courtesy. Office visits are payable on the day you are seen. Please remember you are responsible for all fees, regardless of insurance coverage.

Patient Name: _____ DOB: _____ / _____ / _____

Address: _____ City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home: _____ Work: _____ Email: _____

Reason for today's visit: _____

Past Medical History: (please circle all that apply)

- Anxiety
- Arthritis
- Asthma
- Atrial fibrillation
- Bone marrow transplant
- BPH
- Breast cancer
- Colon cancer
- COPD
- Coronary artery disease
- Depression
- Diabetes
- End stage renal disease
- GERD
- Head trauma
- Hearing loss
- Hepatitis
- Hypertension
- HIV / AIDS
- Hypercholesterolemia
- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate cancer
- Radiation treatment
- Seizures
- Stroke
- Colitis, Crohns

Other:

Past Surgical History: (please circle all that apply)

- Appendix removed
- Bladder removed
- Breast biopsy (right, left, bilateral)
- Lumpectomy (right, left, bilateral)
- Mastectomy (right, left, bilateral)
- Colectomy
- Colostomy
- Gallbladder removed
- Coronary artery bypass
- Angioplasty (PTCA)
- Biological valve replacement
- Mechanical valve replacement
- Heart transplant
- Hip replacement (right, left, bilateral
- Knee replacement (right, left, bilateral)
- Kidney biopsy
- Kidney removed (right, left)
- Kidney stone removed
- Kidney transplant
- Kidney removed
- Hepatectomy
- Liver transplant
- Liver shunt
- Ovaries removed: (endometriosis, cancer, cyst)
- Tubal ligation
- Pancreas removed
- Prostate removed: (cancer, TURP)
- Rectal resection
- Spleen removed
- Testicles removed (right, left, bilateral)
- Hysterectomy (fibroids, uterine cancer, cervical cancer)

Other:

Skin Disease History: (please circle all that apply)

- Acne
- Aetinic keratosis
- Asthma
- Basal cell skin cancer
- Blistering sunburns
- Dry skin
- Eczema
- Flaking/itchy scalp
- Hay fever/allergies
- Melanoma
- Poison Ivy
- Precancerous moles
- Psoriasis
- Squamous cell skin cancer

Other:

DO YOU WEAR SUNSCREEN? ☐ YES ☐ NO

If yes, what SPF: _____

DO YOU TAN IN A TANNING SALON?

☐ YES ☐ NO

DO YOU HAVE A FAMILY HISTORY OF MALIGNANT MELANOMA?

☐ YES ☐ NO

If yes, which relative(s): _____

PLEASE COMPLETE BOTH FRONT AND BACK OF FORM

MEDICATIONS: (please list all current medications)

_____ _____

_____ _____

_____ _____

_____ _____

☐ NO MEDICATIONS

DRUG ALLERGIES: (please list all known allergies and reactions)

_____ _____

_____ _____

☐ NO KNOWN DRUG ALLERGIES

SOCIAL HISTORY:

Smoking status: ☐ Current everyday smoker ☐ Current someday smoker
☐ Former smoker ☐ Never smoker

Alcohol use: ☐ Never ☐ Social ☐ Frequently

Occupation:

ALERTS: (please circle all that apply)		
• Allergy to adhesive • Allergy to latex • Allergy to lidocaine • Artificial heart valve • Medication allergy • Chemotherapy	• Artificial joint replacement • Blood thinners • Defibrillator • MRSA • Antibiotic allergy • Immunosuppressed	• Pacemaker • Required antibiotics prior to procedure • Rapid heartbeat with epinephrine • HIV • Hepatitis • Breast feeding

ARE YOU PREGNANT OR CURRENTLY TRYING TO GET PREGNANT? ☐ YES ☐ NO

REVIEW OF SYSTEMS: Are you currently experiencing any of the following? (Please check yes or no)

Symptom	Yes	No
Are you in generally good health?		
Do you have problems with bleeding?		
Do you have problems with healing?		
Do you have problems with scarring?		

Pharmacy (name/town/phone #):_____

PATIENT FINANCIAL POLICY

Welcome to the offices of Dr's Saperstein, Gottlieb, Schaffran & Berkman

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered *unless* you are in an insurance plan in which we participate. For those patients, applicable co-payments and/or deductibles will be collected.

In the event that your insurance carrier fails to pay for services within 90 dys, you will be billed for the unpaid charges.

Minors *(under 18)*: Must be accompanied by an adult before services can be rendered. The Adult/Guardian who brings in the child will be responsible for all co-payments and deductibles. We do not forward bills to other parties regardless of court rulings or divorce decrees.

This office does *not* bill insurance companies for cosmetic procedures *(not medically necessary).* The patient is financially responsible for all cosmetic procedures when they are rendered.

Patient due balances over 30 days will be assessed a 1.5% monthly (18% annual) service charge, unless other payment arrangements have previously been made with this office. *(This service does not apply to Medicare patients.)*

In the event your account must be turned over to a collection agency, a $10.00 collection fee will be added to your account by this office in addition to any fees charged by the agency.

Medicare:

We are participating providers of the Medicare program. We do accept assignment on all claims. Patients are responsible for meeting their annual $140.00 deductible and paying the 20% co-insurance. We will file with secondary/supplemental carriers.

Your signature below signifies your understanding and willingness to comply with this policy.

_____ _____

Patient/Responsible party signature Date

Harry W. Saperstein, M.D.
Annette J. Gottlieb, M.D.
Robin M. Schaffran, M.D.
Suzanne L. Berkman, M.D.
(310) 854-3003

Medical Treatment Consent

We want you to appreciate issues common to dermatologic conditions and medications..

- Skin conditions often recur and many are chronic. Several common dermatologic conditions can only be controlled but cannot be cured. These conditions will wax and wane but we can help to treat flares of your condition to make you more comfortable.

- Many rashes require customized therapy because every patient responds differently. Repeat visits are often necessary so that we may maximize your treatment plan.

- All drugs have potential side effects. Rare, unpredictable and possibly serious side effects can occur with any medication (even those you buy over-the-counter). Although we will discuss common side effects, it is impossible to review every drug reaction with you. Most medicines are overwhelming safe but unpredictable events can occur. Let us know if you think you are having any reaction.

- Topical creams are "medicines" also and need to be used only as prescribed and only on the appropriate skin areas.

- Some common, generally safe prescription medicines may become extremely dangerous when used together. Make sure and tell us every medicine you take, even if just taken on occasion. Anytime another doctor gives you a medication, or even if just getting a refill, advise your doctor and pharmacist of medications we have given you.

- If you become pregnant, please stop your medications and advise us.

- We cannot provide refills on your medications if we have not seen you in over one year. It is important that we see you periodically to assess your condition and make sure you are on the proper medication for the stage of your condition. We want to be helpful, but it is imperative that the highest standards be met.

We are partners with you in the care of your skin. Follow up visits are often necessary so that we may make alterations to your treatment as your care progresses. Please advise us of any changes that develop while on medications.

Signature: _____ **Date:** _____

Harry W. Saperstein, M.D.
Annette J. Gottlieb, M.D.
Robin M. Schaffran, M.D.
Suzanne L. Berkman, M.D.
(310) 854-3003

General Surgical / Procedure / Biopsy Consent

- As Dermatologists, we employ multiple types of minor procedures to both treat and diagnose your skin condition. Whether it is a spot, rash or a changing or painful bump or lump, these problems may be dangerous or a threat to your health or well-being.

- When we do perform any procedure, whether for diagnosis or treatment, your health and safety are our primary concerns. In addition, cosmetic consequences are always taken into account in any intervention that we do.

- Unfortunately, despite all our expert conscientious care and meticulous approach, **every procedure**, from trivial to life-saving, can leave some mark or residual sign on the skin.

- Infections, recurrences and unexpected side-effects, (some significant), can also occur regardless of the precautions taken to prevent them.

- It is for these reasons that no procedure is done without maximizing the benefit and minimizing the side-effects. No procedure is done unless absolutely necessary for your life, health, safety or comfort.

- Any procedure that is done requires follow up not only by us, but by you as well. If a surgery/biopsy is not healing, or if a lesion grows back or if something is behaving in a way that you did not expect, it is up to you to contact the office immediately so we may address the issue. We cannot help to solve any problems unless you call and inform us.

- If you have questions, please ask us freely and openly before any procedure so that we can continue to explain the details of the process. We will gladly explain why one procedure is picked over another and if a "Non-surgical option" is available.

Signature: _____ **Date:** _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Saperstein, Gottlieb, Schaffran & Berkman, MD's

PLEASE READ CAREFULLY

This form authorizes Saperstein, Gottlieb, Schaffran & Berkman MD's to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities.

Before signing please read our Notice of Privacy Practices to gain a clear understanding of how we may use and disclose your PHI. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to PRIVACY OFFICIAL. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

PATIENT'S INFORMATION

Name: _____

Address: _____

Phone: _____

DURATION

This authorization shall be effective immediately and remain in effect until _____.

PATIENT'S SIGNATURE

☐ I, by signing this form, am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

☐ I, by signing this form, revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signed: _____ Date: _____

If not signed by the patient, please indicate relationship:

__ Parent or guardian of minor patient
__ Guardian or conservator of an incompetent patient
__ Beneficiary or personal representative of deceased patient

Name of Representative: _____

You re entitled to a copy of this consent after you sign it.

Include completed form in the patient's chart.