DERMATOLOGY CENTER OF NORTH JERSEY

BOARD CERTIFIED DERMATOLOGISTS

JONATHAN A. GOLD, M.D.
ROY STERN SEIDENBERG, M.D.

MATTHEW BRETT QUAN, M.D.
JOANNA M. ZURADA, M.D.

Name: _____ Age: _____ DOB: _____
(Date of Birth)

Sex: M F Marital Status: S M W D S.S. # : _____

Address: _____
Street City State ZIP

Phone: Home(___)_____ Work/Daytime(___)_____Cell(___)_____

Occupation: _____ School Name (if still a student): _____

Primary Insurance Carrier: _____

Insured's Name (if different from above): _____ DOB: _____

Policy Number: _____ Group Number: _____

Patient 's Relationship to Insured : Self Spouse Child Other

Insured's Employer (Name & Address): _____

Secondary Insurance Carrier: _____

Insured's Name (if different from above): _____ DOB: _____

Policy Number: _____ Group Number: _____

Patient 's Relationship to Insured : Self Spouse Child Other

Primary Care Physician: _____ **Physician's Phone # :** _____

Pharmacy Name : _____ **Pharmacy Phone # :** _____

YOU ARE RESPONSIBLE TO KNOW HOW YOUR INSURANCE POLICY WORKS AND TO PRESENT ANY REFERRALS OR OTHER NECESSARY DOCUMENTATION.
YOU ARE RESPONSIBLE FOR ALL COPAYMENTS, COINSURANCES AND DEDUCTIBLES.
PAYMENT IS EXPECTED AT THE TIME OF THE VISIT.
$5 WILL BE ADDED TO COPAYMENTS NOT MADE AT THE TIME OF THE VISIT.

Acknowledgement and Authorization to release information and assignment of benefits:
I **acknowledge** that in consideration for treatment rendered to me and/or my child I am responsible for all charges and fees for services rendered. I understand that although I may have insurance to cover the cost of treatment, I remain responsible for payment. I also understand that there are many insurance companies, such as Medicaid, that this office does not participate with. I hereby **authorize** that any payment of insurance benefits for services furnished to me by Dr. Gold, Dr. Quan, Dr. Stern Seidenberg, and/or Dr. Zurada be made directly to the doctor unless clearly noted as having been paid by me. I **authorize** the release of information needed to determine these benefits payable for related services.

_____ _____
Signature (Patient or Responsible Party) Date

DERMATOLOGY CENTER OF NORTH JERSEY

I. HAVE YOU PREVIOUSLY HAD A SKIN PROBLEM OR BEEN UNDER THE CARE OF A DERMATOLOGIST ? ..... yes / no
IF "YES", DESCRIBE: _____

_____

II. DO YOU TAKE ANY MEDICATIONS / DRUGS (Including Birth Control Pills or Over The Counter Products) ? ..... yes / no
IF "YES", LIST: _____

_____

III. ARE YOU **ALLERGIC** TO ANY MEDICATION ? ..... yes / no
IF "YES", LIST: _____

IV. ARE YOU PREGNANT OR BREAST-FEEDING ? ..... yes / no

V. DO YOU HAVE ANY BLEEDING PROBLEMS ? ..... yes / no

VI. DO YOU NEED TO TAKE ANTIBIOTICS BEFORE GOING TO THE DENTIST ? ..... yes / no

VII. ARE YOU A SMOKER? .... yes / no If yes, how many packs per day? _____

VIII. HAVE YOU - OR ANY MEMBERS OF YOUR FAMILY (SPECIFY WHO) – had any of the following conditions ?

	MYSELF	**FAMILY**
1. Eczema	yes / no	yes / no
2. Asthma	yes / no.	yes / no
3. Hayfever	yes / no..	yes / no
4. Psoriasis	yes / no.	yes / no
5. Skin Cancer	yes / no.	yes / no

IX. HAVE **YOU** EVER HAD ANY OF THE FOLLOWING CONDITIONS?

1. High blood pressure ..... yes / no
2. Diabetes ..... yes / no
3. Heart disease (angina, pacemaker) ..... yes / no
4. Heart valve problems ..... yes / no
5. Intestinal disease (ulcer, colitis) ..... yes / no
6. Kidney disease ..... yes / no
7. Arthritis, joint problem or bone disease ..... yes / no
8. Cancer ..... yes / no
9. Hepatitis ..... yes / no
10. HIV / AIDS ..... yes / no

I would like a full body exam where the doctor will examine my skin for undetected benign or malignant lesions ..... yes / no

X. WHO REFERRED YOU TO THIS OFFICE?

Physician _____ Friend _____ Insurance Book _____ Internet / Yellow Pages _____
Please be specific:

_____

If Physician, please give address:

_____

Name: _____ **Date:** _____

Dermatology Center of North Jersey
Board Certified Dermatologists

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Patient Acknowledgement

The government has passed a new law to help insure the privacy and confidentiality of patient records. Part of this statute requires doctors to inform patients of their rights under this new law. Therefore, our office has prepared a comprehensive **Notice of Privacy Practices** – a document which provided information about how **The Dermatology Center of North Jersey** may use and disclose protected health information ("PHI") about you. You have the right to review this Notice of Privacy Practices and ask questions about our privacy practices.

You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care services, but we are not required to agree to this restriction.

By signing this form you acknowledge that you have been informed about this new law regarding patient confidentiality and about our Notice of Privacy Practices, and that you have been given the opportunity, should you so desire, to review this comprehensive document.

You may discuss my medical file with the following:

Name _____ Relationship _____ Phone# _____

Name _____ Relationship _____ Phone # _____

Name of Patient _____

Signature _____ Date _____
(Patient or Responsible Party)

Dermatology Center of North Jersey
Board Certified Dermatologists

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act - **HIPPA**. This Federal Law prohibits any staff member of Dermatology Center of North Jersey from discussing appointments, medications, test results or treatment plans with anyone other than the patient. Often this causes difficulty for some patients who would like family members or caretakers to obtain information for or about them. This becomes especially important if your spouse or adult children assist with making appointments for you or if you are a college student away at school and your parents assist you with prescriptions and appointments.

The law provides that you can permit one or more individuals to discuss your medical condition, confirm appointments or obtain results on your behalf. Below is a list which you may complete. Only those individuals listed may obtain information about you.

You may discuss my medical file with the following:

Name of Individual	Relationship to Patient	Phone Number

Please place a check mark next to the following methods we may use to contact you:

You may leave a message	Regarding Appointments	Regarding Medical Information
Answering machine at home	_____	_____
Anyone at home	_____	_____
Work phone	_____	_____
Cell phone	_____	_____

Patient or Guardian Signature_____ Date _____