FEINSTEIN DERMATOLOGY & COSMETIC SURGERY

6140 W. Atlantic Avenue | Delray Beach, FL 33484
P: (561) 498-4407 | F: (561) 498-4480
www.feinsteindermatology.com

NEW PATIENT INTAKE FORM

Today's Date: ________________ Reason for Visit: ____

How did you hear about Feinstein Dermatology: ____

PATIENT INFORMATION

Title: (circle one) Mr. Mrs. Ms. Dr. Other: _________

First Name: __________________________________ Last Name: __________________________________ Middle: ________

If minor, Parent/Guardian of Patient: __________________________________ Phone Number: ____________________

Social Security Number: _____________________ Date of Birth: ________________

Sex: ______ Marital Status: __________________ Email address: ____

Permanent (Local) Address: ____ City/State/Zip: _____________________________

Secondary (Out of State) Address: _____________________________________ City/State/Zip: ______________________________

Home Phone: ____________________ Cell Phone: ____________________________ Work Phone: ___________________

Preferred Contact Method: ☐ Text Message ☐ Phone call/voicemail ☐ Home Phone ☐ Cell Phone

Employer: ____ Occupation: _________________________________

Race: __________________ Ethnicity: _________________________ Language Spoken: ________________________

Pharmacy Name: _____________________City: ________________Phone: ___________ Cross Streets: _____________________

EMERGENCY CONTACT

Name: _________________________________ Relationship to Patient: _______________________ Phone: __________________

INSURANCE INFORMATION

Primary Insurance: _______________________________ ID Number: ____________________________

Secondary Insurance: ________________________________ ID Number: ____________________________

Name of Policy Holder: ____

Relationship to Policy Holder: ___________________________ Policy Holder Phone Number: ______________________

PRIMARY CARE

Primary Care Physician: _______________________________________ Phone Number: ________________________

IF YOU ARE 65 YEARS OR OLDER:

Have you **EVER** received a pneumonia vaccination?
Yes☐ No☐

Do you have a health care proxy in the event you are unable to make your own medical decisions?
Yes☐ No☐

ARE YOU INTERESTED IN: (PLEASE CHECK ALL THAT APPLY)

____ **Cosmetics**: Botox, Dermal Fillers, Sculptra

____ **Aesthetics**: Microneedling, Acne/Customized Facials, Hydrafacial

____ **Laser**: BBL, Halo, Skintyte

____ **Skincare Products**: Anti-aging, Brightening

X ____ **X** _____________________________
Signature **Date**

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PAST MEDICAL HISTORY: (PLEASE CHECK ALL THAT APPLY)

Patient's Name____________________________________ **DOB:** ______________ **Date** _________________

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Atrial fibrillation
- ☐ Colon Cancer
- ☐ COPD
- ☐ Breast Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Elevated Blood Pressure
- ☐ Renal Disease
- ☐ Seizures
- ☐ Hepatitis B or C (please circle)
- ☐ HIV
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory Bowel Disease
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Lung Cancer
- ☐ Prostate Cancer
- ☐ Radiation Treatment

☐ Other ____

☐ **None**

PAST SURGICAL HISTORY: (PLEASE CHECK ALL THAT APPLY)

- ☐ Coronary Artery Bypass
- ☐ Kidney Transplant
- ☐ Tubal ligation
- ☐ Appendix Removed
- ☐ History of Breast Implants
- ☐ History of Colectomy
- ☐ Hysterectomy
- ☐ Lumpectomy: ☐ Left ☐ Right
- ☐ Mastectomy: ☐ Left ☐ Right
- ☐ Heart Valve Replacement
- ☐ Prostate Removed
- ☐ Hip Replacement: ☐ Left ☐ Right
- ☐ Spleen Removed
- ☐ Knee Replacement: ☐ Left ☐ Right
- ☐ Heart Transplant

☐ Other ____

☐ **None**

SKIN DISEASE HISTORY: (PLEASE CHECK ALL THAT APPLY)

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Basal Cell Skin Cancer
- ☐ Dysplastic Nevus of Skin
- ☐ Eczema
- ☐ Melanoma
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Suspected Skin Cancer

☐ Other ____

☐ **None**

Do you have a family history of skin cancer? ☐ Yes* ☐ No

*If **Yes**, select: ☐ Melanoma** ☐ Basal / Squamous Cell ☐ Unsure

**If Melanoma, which relatives(s)? _________________________________

~ Ask about our VIP Memberships and complimentary cosmetic consultations! ~

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MEDICATIONS: (PLEASE ENTER ALL CURRENT MEDICATIONS, INCLUDING VITAMINS AND OVER-THE-COUNTER)

____
____
____
____
____
____

ALLERGIES: (PLEASE ENTER ALL ALLERGIES)

____
____
____
____
____

☐ Currently smokes ☐ Has smoked in the past ☐ Never smoked

REVIEW OF SYSTEMS: (PLEASE SELECT YES OR NO)

☐ Yes ☐ No	Unintentional Weight Loss/Gain	☐ Yes ☐ No	History of Heart Attack
☐ Yes ☐ No	History of Herpes - Oral or Genital	☐ Yes ☐ No	Swelling of Legs
☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Pacemaker or Defibrillator
☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No	Allergy to Adhesive
☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Hair or Nail Changes
☐ Yes ☐ No	Gastrointestinal Complaints	☐ Yes ☐ No	Rash
☐ Yes ☐ No	Dizziness	☐ Yes ☐ No	Bleeds Easily/Excessively
☐ Yes ☐ No	Numbness	☐ Yes ☐ No	Problems/History of Scarring
☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Problems with Healing
☐ Yes ☐ No	Urinary - Any Complaints	☐ Yes ☐ No	Breast Lumps/Lesion
☐ Yes ☐ No	Cataracts/Glaucoma/Blurry Vision	☐ Yes ☐ No	Currently Pregnant or Planning a Pregnancy or Breastfeeding
☐ Yes ☐ No	Ear, Nose, Mouth - Any Complaints		
☐ Yes ☐ No	Artificial Joints within past two years	☐ Yes ☐ No	History of MRSA
☐ Yes ☐ No	Joint or Muscle Pain	☐ Yes ☐ No	Currently taking Blood Thinners
Miscellaneous______________________________			

SIGNATURE:

Completed by: ☐ Patient ☐ Patient's Parent ☐ Guardian ☐ Medical Assistant

Print Name (if not patient): ______________________________

X ______________________ X ______________________ X ____________

Print Patient Name Signature Date

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HIPAA, 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.

1. May we leave appointment information on your answering machine or cell phone? ☐ Yes ☐ No

   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

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

Name: ________________________ Phone: ________________ Relation: ______________
Name: ________________________ Phone: ________________ Relation: ______________

X ________________________________ **X** ________________________
Signature **Date**

AUTHORIZATIONS

For the release of medical records/past medical history:
I authorize the release of any medical information required by my insurance carrier(s) or Feinstein Dermatology needed for any related claim or for use in treating any and all conditions. 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. Payment is required at the time services are rendered.

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 or cancel with less than 24 hours notice for your scheduled *appointment* and a ***$100.00*** charge for any scheduled *procedure* (i.e., surgery, ED&C, shave removal, etc.). 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.

The information requested on this form must be completed in its entirety and will remain confidential.

X ______________________ ______________________ ______________________
Signature **Print Name** **Date**