Dermatology *Partners*, Inc.
65 WALNUT STREET, SUITE 480
WELLESLEY, MA 02481
P: 781.431.7733 F: 781.235.2665

Administrative Use Only

**New Patient** **Current Patient**

**Provider:** _____

**Date:** _____

# Patient Information Sheet

**Please bring your insurance card to your appointment**

Patient Name:_____ Date of Birth:_____ Gender: M F

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

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

Email: _____

Emergency Contact:_____ Relationship:_____ Phone Number:

Would you like to receive e-mail updates regarding new products, procedures or events? Yes / No If yes, check your interest(s): ☐ Medical Dermatology ☐ Cosmetic Dermatology

How did you hear about our practice (Circle One)?

Physician Friends/Family Radio Company website Insurance website

**Please give us the following information to facilitate our communication with your primary care physician:**

Primary Care Name (first and last): _____ City:_____

Pharmacy Name:_____ City:_____ Phone:_____

Primary Insurance:_____ ID #:_____ Group #:_____

Cardholder Name:_____ Cardholder D.O.B.:_____ Relationship:_____

Secondary Insurance:_____ ID #:_____ Group #:_____

Cardholder Name:_____ Cardholder D.O.B.:_____ Relationship:_____

I have been able to review the Dermatology Partners Notice of Privacy Practices (available in our office). This notice provides information about how Dermatology Partners may use and disclose my protected health information, what its legal duties are regarding my protected health information, what my rights are regarding my protected health information, and how I can file a complaint about these privacy practices. I understand that if I have additional concerns, I may ask the HIPAA compliance officer at Dermatology Partners for clarification.

By signing below, I also hereby authorize my insurance benefits (if applicable) to be paid directly to Dermatology Partners, Inc. I realize that I am responsible for the payment of non-covered services, co-payments, and deductibles. I also authorize the release of pertinent information to insurance carriers.

Patient Signature _____ Date_____

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[illegible]
RACHEL HERSCHENFELD, MD
CARIN LITANI, MD
HILARY HAIMES, MD
LIZANNE NOBLE, NP
MORGAN MURPHREY, MD

Patient Name _____ Date of Birth _____ Date _____

Do you take Blood Thinners? Y N

Defibrillator or Pacemaker? Y N

Allergies:

Current medications:

**Reason for today's visit** (chief complaint)

_____

_____

**Current or past problems** (Review of symptoms)

| | Yes | No | |
|---|---|---|---|
| General Health | ☐ | ☐ | _____ |
| Eyes | ☐ | ☐ | _____ |
| Ears/Nose/Throat/Mouth | ☐ | ☐ | _____ |
| Heart | ☐ | ☐ | _____ |
| Lungs | ☐ | ☐ | _____ |
| Stomach/Bowel | ☐ | ☐ | _____ |
| Kidneys | ☐ | ☐ | _____ |
| Arthritis/Muscles/Joints | ☐ | ☐ | _____ |
| Skin | ☐ | ☐ | _____ |
| Headaches/Seizures | ☐ | ☐ | _____ |
| Psychological disorder | ☐ | ☐ | _____ |
| Thyroid/Diabetes | ☐ | ☐ | _____ |
| Blood/Bleeding disorder | ☐ | ☐ | _____ |
| Allergic/Immunologic | ☐ | ☐ | _____ |

Females: Are you pregnant? _____ yes _____ no Planning to become pregnant? _____yes _____ no

**Family History** (past family and social history)
Mother: living / deceased _____ age Father: living / deceased _____ age
Number of your children _____ age(s) _____
Check the following that have occurred in your family