sperling *dermatology*

FLORHAM PARK, NJ

Dear Patient,

Thank you for choosing Sperling Dermatology, LLC. We are committed to providing you with quality medical care. We offer a full range of medical, cosmetic and surgical dermatology for adults and children. Please help us by filling out these forms prior to your first appointment to help us better serve you. We look forward to a bright future together. Your opinion, concerns, and questions are always welcomed. Please do not hesitate to contact us.

Thank you,

Shari Sperling, DO, FAAD, FAOCD

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FLORHAM PARK, NJ

Date: ____________________

Patient Information

Last Name: __________________________Middle Initial: _____ First Name: ________________
Address: ______________________________ City: _________________ State: ___ Zip: ______
Home Phone: ________ __________________Cell Phone: _________________________________
Occupation: ____________________________ Office Phone: ______________________________
SSN: _____________________________ Marital Status: _________________________ Sex: M/F
DOB: ____________ Age: __________ Email: ____

Emergency Contact

Name: _______________________________ Phone: ____________________________________
Relationship: __________________________

Primary Physician

Name: ____________________________ Phone: _______________________________________

Referred By

Doctor: ___________ Friend: ______________ Internet: ___ Insurance: ___ Other: __________

Insurance Information

Primary Insurance: _______________ Policy Holder: _______________Relationship: ________
Insured DOB: __________________________ Insured SSN: ______________________________
Policy #: ______________________________ Group #: __________________________________
Policy Holder Address: ____ Same as Above: _____
Secondary Insurance: _____________ Policy Holder: _______________ Relationship: _______
Insured DOB: __________________________ Insured SSN: ______________________________
Policy #: ______________________________ Group #: __________________________________

Pharmacy Name/ Location: __________________________ Phone: _______________________

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I hereby authorize Sperling Dermatology, LLC to release any of my medical information necessary to process this claim and all future claims and also authorize payments directly to the provider. A photocopy of this assignment shall be valid as the original.

I certify that I am financially responsible for all charges including the deductible, co- payment, charges for cosmetic services, and collection fees not covered by your insurance company.

I hereby voluntarily consent for examination and treatment by Sperling Dermatology, LLC.

Signature: ___________________________________ Date: ____________________________
Responsible Party Name (*if different from patient*) __________________ Signature: __________________
Relationship to Patient: ___________________________

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FLORHAM PARK, NJ

Date: ____________

Medical History

Name: ________________________________ DOB: _____________________________

Reason for today's visit: ____

Past Medical History: (Please check all that apply)

- Asthma
- Autoimmune Disease
- Arthritis (specify) __________________
- Kidney Disease/ End Stage Renal Disease
- Heart Disease
- Hepatitis
- High Cholesterol
- Radiation (specify) __________________
- Seizures
- Pacemaker
- Organ/ Bone Marrow Transplant
- Anxiety/ Depression
- Diabetes
- GERD
- HIV/ AIDS
- Hypertension
- Thyroid Problems (specify) _____
- Chemotherapy (specify) ________
- Stroke
- Defibrillator
- Artificial Joint

Skin History:

- Skin Cancer (specify) _______________
- Melanoma (location/ year) ____________
- Eczema
- Atypical Moles
- Hives
- Seasonal Allergies
- Scarring/ Keloids
- Actinic Keratosis (pre cancers)
- Cancer (specify) ______________
- Psoriasis
- Herpes Simplex/ cold sores
- MRSA
- Bleeding/ Clotting Disorders

Family History of Melanoma/ Skin Cancer: Y/ N (specify) _____________________________

Past Surgical History/ Hospitalizations:

____

Medications (prescriptions, over the counter, vitamins, supplements):

____

____

Allergies: ____

Allergies to bacitracin/ latex/ epinephrine/ adhesives: (circle one if applicable) Y/ N

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Female Patients: Are you pregnant: Y/ N Last Menstrual Period: _________________
Nursing: Y/ N

Marital Status: (circle one)
Single/ Married/ Divorced/ Domestic Partner/ Separated/ Widowed

Social History:
Tobacco: Y/ N Former smoker: Y/ N If yes, how much: ___________________________
Alcohol: Y/ N/ Occasional If yes, ________ drinks/ day/ week
IV Drugs: Y/ N If yes, what? ___________ How often? _________

Sun History:
Do you wear sunscreen? Y/ N If yes, what SPF? ___________________________
Have you ever used a tanning booth? Y/ N If yes, how often? ___________________________
Have you had sunburns in the past? Y/ N If yes, estimate how many? ___________________

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FLORHAM PARK, NJ

Patient Authorization for Release of Protected Health Information

Name: ________________________________ DOB: _________________ Date: ____________

HIPAA Policy

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of Sperling Dermatology, LLC 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.

If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results on your behalf, please indicate their name(s) below. Only these individuals will be provided with information.

I have the right to revoke this Authorization, in writing, at any time, except to the extent Sperling Dermatology, LLC has taken action in reliance on this authorization.

Name of individual: ____________________ Relationship: ________________________
Name of individual: ____________________ Relationship: ________________________
Name of individual: ____________________ Relationship: ________________________

Signature of Patient/ Parent/ Guardian: _______________________ Date: ________________

I also consent for Sperling Dermatology, LLC to contact me by the following methods:

Leave message regarding medical information on:
home phone ___ work phone ___ cell phone ___ None ___

Leave message regarding appointments on:
home phone ___ work phone ___ cell phone ___ None ___

Signature: ______________________________ Date: ______________________________

Receipt of Notice of Privacy Practices Written Acknowledgement Form

This notice describes how medical/ protected health information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Summary:
By law, we are required to provide you with our Notice of Privacy Practices (NPP).

As a patient, you have the following rights:

1. The right to inspect and copy your information
2. The right to request corrections to your information
3. The right to request that your information be restricted
4. The right to request confidential communication
5. The right to a report of disclosures of your information
6. The right to paper copy of the Notice

We want to assure you that your medical/ protected health information is secure with us. The Notice contains information about how we will insure that your information remains private.

I hereby acknowledge receipt of Sperling Dermatology, LLC's Notice of Privacy Practices.

Name: _____________________________ Signature: __________________________________
Date: ______________________________
Parent/ Guardian (print): ____________________ Relationship to patient: ________________
Signature: _________________________________ Date: ________________________________

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FLORHAM PARK, NJ

Please indicate your current interest level below. If you know someone else who is interested in one of the services below, please have them contact our office.

Current Services offered by Sperling Dermatology	No Interest	Request Info via Email	Would like to discuss at today's appointment
CoolSculpting			
Botox			
Fillers			
Laser Hair Removal			
Laser for Broken Blood Vessels			
Laser for Pigmentation			
Laser for Tone and Texture			
ClearLift (Lunch Time FaceLift)			
Near Infrared			
Laser Tattoo Removal			
Photofacial			
Fractional Ablative Laser			
Nail Fungus Laser Treatment			
Cosmetic Peels			
Latisse (for eyelashes)			
Sclerotherapy (for spider veins)			
Monthly Subscription Package for any service above			

Services we are considering offering in the future	No Interest	Request Info via Email	Would like to discuss at today's appointment
Hair Transplantation/ NeoGraft			
MiraDry/ Sweat Reduction			
Private Label Skin Care products sold in office			

Name: ______________________________ **Email:** __________________________