Diana S. Leu, MD

Dermatology 330 Ratzer Road, Suite D17, Wayne, NJ 07470 Phone: 973-925-7077 Fax: 973-925-7078

* <u>PATIENT INFORMATION</u>

Name (Last, First, Middle):		Date:
Date of birth:	_	Home phone #:
Address:		Cell phone #:
City: State:	Zip Code:	Gender: \Box M \Box F
E-mail address (used for appointment reminders	s only):	
Marital status: 🗆 Single 🛛 🗆 Married 🔅 Di	ivorced 🗆 Widowed 🗆 Separate	ed Check if minor (less than 18): \Box
How did you learn about the practice?		
Primary care physician:		Phone # (if known):
Referring doctor (if applicable):		Phone # (if known):
Occupation:	Employer:	
✤ <u>EMERGENCY CONTACT</u>		
		onship to patient:
Primary phone #:	\Box cell \Box home Secondary phon	ne #: □ cell □ home
★ ADDITIONAL INCLUDANCE INFORM	ATION	
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		e poncynomer.
This applied to: Primary Insurance 🗆 Seco		
Policy holder's name (Last, First, Middle):		
		birth:
	-	
Primary phone #:	\Box cell \Box home Secondary phon	ne #: □ cell □ home
* ASSIGNMENT, RELEASE, AND PATH	ENT'S FINANCIAL DESDONSIR	II IES
		LLC. I understand that I am financially responsible for any
balances, including co-payments, deductibles, and	nd co-insurance. Co-payments are e	expected at the time of the visit.
I also authorize the doctor and staff at this office I authorize the use of my signature on all insurat		to my insurance companies to process my claims. e substituted for the original.
		C C
		not necessarily mean that the insurance company will cover finding that many insurance companies are now charging
		ance-eligible portions of their office visit. This may be in
		ance company, it will be billed to you after the office visit.
		Date:
		nust sign above and fill in the information below
Parent/guardian name (print):		Relationship to patient:

* <u>PHARMACY INFORMATION</u> Please provide as much information as possible for your pharmacy:

Pharmacy name:	Pharmacy phone #:
· · · · · · · · · · · · · · · · · · ·	* *

Pharmacy address:

Name:

HISTORY AND INTAKE FORM

DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING: (please CHECK all that apply)

End Stage Renal Disease Prostate Cancer Anxietv Arthritis GERD/eflux of the esophagus **Radiation Treatment** Asthma **Hearing Loss** Seizures Hepatitis, Type:____ Stroke **Atrial Fibrillation Benign Prostatic Hypertrophy** High Blood Pressure Crohn's Disease Glaucoma High Cholesterol **Bone Marrow Transplantation** Liver Disease **Breast Cancer** HIV/AIDS Lupus **Colon Cancer** Hyperthyroidism Multiple Sclerosis Hypothyroidism COPD/Emphysema Psychiatric Care Leukemia Heart Disease Ulcerative Colitis Depression Lung Cancer **Cancers not listed above:** Diabetes Lymphoma Other

* **PAST SURGICAL HISTORY**: (please list) *Check if none*

✤ SKIN DISEASE HISTORY: (please CHE	CK all that apply)	
Precancerous sunspots	Hay Fever/Allergies	Squamous Cell Skin Cancer
Basal Cell Skin Cancer	Melanoma	Keloids/thickened scars
Blistering Sunburns	Precancerous Moles	Other
Eczema	Psoriasis	
Do you have a family history of Melan	U U	sunscreen? Yes□ No□
If yes, which relative(s)?	Do you tan	in a tanning salon? Yes□ No□

◆ Allergies to Medications: Check if none □

Vee

PLEASE ANSWER THE FOLLOWING (PLEASE CHECK YES OR NO):			
Do you have a pacemaker or defibrillator?		No□	
Do you require premedication with			
antibiotics prior to procedures?		No□	
Do you have an allergy to adhesive?		No□	
Do you have an allergy to antibiotic ointment?		No□	
Do you have an allergy to lidocaine/numbing agents?		No□	
Do you get a rapid heart beat with epinephrine?		No□	

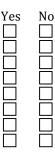
SOCIAL HISTORY: (Please check if applies)

Cigarette use: Currently smoke - daily Currently smoke - not daily Smoked in the past Never smoked

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS? (PLEASE CHECK YES OR NO)

	Yes	No
Changing mole		
Bleeding tendency		
Fever or chills		
Chest pain		
Cough		
Hay fever		
Joint pain		
Frequent urination		
Unintended weight loss		

Shortness of breath	1
Sore throat	
Excessive thirst	
Headaches	
Blurry vision	
Anxiety	
Depressed mood	
Abdominal pain	



Women only: Are you pregnant? Yes□ No□ Are you planning a pregnancy? Yes□ No□

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______, was given the opportunity to review a copy of Patient Name
Diana S. Leu, MD's Notice of Privacy Practices. I understand a copy of the Notice of Privacy Practices is available upon my request.

Date:	
If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above and fill in the information below.	
elationship to patient:	

CONSENT FOR TELEPHONE MESSAGES AND SHARING HEALTH INFORMATION

I agree that telephone messages regarding my appointments, prescription renewals, lab results, and all other Protected Health Information may be left for me on voicemail systems and answering machines at any numbers provided to you by me.

◆Yes:

• No. Please only leave information on this phone number's answering machine/voicemail:

• No, do not leave any information on my voicemail except appointment reminders:

I agree that my Protected Health Information may be shared with the following individuals:

• **Spouse:** Yes:_____ No:_____

• Other individuals:

Signature:_____ Date:_____ If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above and fill in the information below.

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above and fill in the information below.

Parent/guardian name (print):______ Relationship to patient:_____

•I understand that I can change any of the foregoing agreements at any time by giving written notice to Diana S. Leu, MD

MEDICAL ADVISEMENT

Please note that Diana S. Leu, MD advises full skin examinations yearly for the purpose of skin cancer screening for all adults. We encourage you to make an appointment. If you have a history of skin cancer, more frequent full skin examinations may be advised.