DSH
Dermatology & Skin Health

Gary Mendese, MD
Stephen Moyer, DO
Robert Murgia, DO
Daniel O'Connor, MD
Todd Wechter, MD
Neera Nathan, MD
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Alaina Iannazzi, PA-C
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Stephanie Grant, NP
Jane Tallent, NP
Christine Horrigan, NP
Lindsey Ramsey, RN
Brooke Comire, RN

Please Complete All Items. Please Print Clearly.

PATIENT INFORMATION:

Name: _____
First Last Middle Initial

Mailing Address: _____

City: _____ State: _____ Zip: _____

D.O.B. _____/_____/_____ Sex: _____ Marital Status: _____ SSN: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Employed: _____ Y _____ N Primary Care Doctor: _____

Emergency Contact: _____
Name Phone Relationship

If minor list all legal guardians: _____

_____

May we share medical information with this person: _____ Y _____ N

INSURANCE POLICY HOLDER INFORMATION:

Primary Insurance Company: _____

Subscriber Name: _____
First Last Middle Initial

D.O.B. _____/_____/_____ Sex: _____ SSN: _____

Relationship to Patient: _____

Secondary Insurance Company: _____

Subscriber Name: _____
First Last Middle Initial

D.O.B. _____/_____/_____ Sex: _____ SSN: _____

Relationship to Patient: _____

**Please bring your insurance cards and a photo ID to your appointment.
** Insurance policy holder DOB is required for billing purposes. Information will not be shared, Thank you.

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Directions to Dover Office
784 Central Ave. Dover, NH

Our Dover office is across the street from Wentworth Douglass Hospital.
Take Exit 9 off of the Spaulding Turnpike (Rte 16) Take a right off the exit. At the major intersection of Five Guys restaurant and Chili's restaurant take a right onto Central Ave. Count four lights. Right after the Emergency entrance to the hospital on your left, watch for the 2nd street on the right (Abbott St.). You can turn onto Abbott St. and take an immediate left into our upper lot directly behind the office. We have additional parking if you stay on Central Ave. and turn right at the traffic light just after our building. For those who need handicapped parking please use the Abbott St. entrance.

Directions to Newington Office
2299 Woodbury Ave. Newington, NH

From the South
Take I-95 North. Take exit 4 (left exit) and merge onto NH-16 towards White Mountains. Take the Gosling Rd. exit and turn right passing McDonalds on your left. Take a left at the next traffic light onto Woodbury Ave. The Beane Farm will be on the right, we are in that building.

From the North
Take NH-16 south to Exit 3 towards Woodbury Ave. As you start down Woodbury Ave. you will see The Beane Farm on your left. Make a U-turn at the next light. We are located in The Beane Farm building, which will be on your right.

Directions to Londonderry Office
50 Michels Way Londonderry, NH

Take I-93 to Exit 4 to merge onto NH-102 W/Nashua Rd toward Londonderry (pass by Wendy's on the right).
Turn right onto Michels Way at the traffic circle, take the 1st exit onto General Bell Dr. We're located on the 2nd floor.

Directions to Bedford Office
160 South River Rd. Bedford, NH

Take NH-101 W/State Rte 101 W. Take I-293 N to Kilton Rd in Bedford. Take the Kilton Rd exit from State Rte 101 W.
Continue onto Kilton Rd. Use the right 2 lanes to turn right onto US-3 S. Turn right on South River Rd.
We are located on the 2nd floor of the medical building.

784 Central Avenue
Dover, NH 03820

2299 Woodbury Ave., Ste. 3
Newington, NH 03801

50 Michels Way, Suite 202
Londonderry, NH 03053

160 South River Road
Bedford, NH 03110

23 Centennial Drive
Peabody, MA 01960

P: 603-742-5556 F: 603-742-8668

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History and Intake Form

Patient's Name: _____
First Last Middle Initial

Race: _____ Ethnicity: _____

Reason for Visit: _____ Primary Care Physician: _____

How did you hear about us? _____

Past Medical History: (please circle all that apply)

Anxiety Arthritis
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Depression
Diabetes
End Stage Renal Disease GERD
Hearing Loss
Heart Disease
Hepatitis
High Blood Pressure
High Cholesterol
HIV/AIDS
Leukemia
Lung Cancer
Lymphoma Prostate Cancer
Radiation Treatment Seizures
Stroke
Thyroid Disease

Past Surgical History: (please circle all that apply)

Appendix Removed
Tonsils Removed
Bladder Removed
Mastectomy (Right,Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Colectomy
Gallbladder Removed
Coronary Artery Bypass
PTCA
Valve Replacement
Heart Transplant
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed
Pacemaker
Prostate Removed
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Carcinoma Surgery
Squamous Cell Carcinoma Surgery

TWO SIDED DOCUMENT - PLEASE COMPLETE BOTH SIDES

Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Testicles Removed (Right, Left, Bilateral)
Melanoma Surgery
Spleen Removed
Other _____

Patient of Child Bearing Potential: (please circle all that apply)

Pregnant
Breastfeeding
Trying to get pregnant

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison lvy
Precancerous Moles
Psoriasis
Rosacea
Squamous Cell Skin Cancer
Other _____

Do you wear Sunscreen? _____ Y _____ N If yes, what SPF? _____

Do you tan in a tanning salon? _____ Y _____ N

Family History:

Family history of: Melanoma? _____ Y _____ N If yes, who? _____

Basal Cell Carcinoma? _____ Y _____ N If yes, who? _____

Squamous Cell Carcinoma? _____ Y _____ N If yes, who? _____

Social History: (please circle all that apply)

Cigarette Smoking:
Non-smoker
Smoker
Quit: former smoker

Do you ever consume alcohol? _____ Y _____ N

If yes, how much/how often? _____

Medications: (please enter all current medications **with dosage**)

_____

_____

Allergies: (please enter all allergies)

_____

_____

Pharmacy: _____

Name Address Phone

TWO SIDED DOCUMENT - PLEASE COMPLETE BOTH SIDES

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NOTICE OF HEALTH INFORMATION PRACTICES SUMMARY

We are required by federal law to provide a Notice of Privacy Practices that describes how health information that we maintain about you may be used or disclosed. The Notice describes each use and disclosure that we are permitted to make, and provides a description of your rights and obligations under federal and state privacy laws.

USES AND DISCLOSURES

We are permitted to use and disclose your health information under a variety of circumstances. Sometimes we must obtain your authorization before we use or disclose that information, but in other circumstances, we may use your information without your authorization and without informing you of the use or disclosure. Some of the reasons that we may use or disclose your information include:

- To provide information about your health condition to others who may treat you.
- To provide information about the treatment that we provided in order to obtain payment for your health plan.
- To report a communicable disease, domestic violence or criminal activity.
- To comply with a court order requiring the disclosure of your medical record.

These examples are merely illustrative. For a full description of the uses and disclosures that we are permitted to make, consult our full Notice of Health Information Practice that may be requested from our office and is available for review in our waiting room.

YOUR RIGHTS

While the records that we maintain about you belong to us, under federal privacy law you have a variety of rights with respect to the information maintained in those records. For instance, you have the right to access and receive a copy of the health information that we maintain about you and to request that we amend any of the information that you believe is incomplete or incorrect. In addition, you may request that we provide you with a list of each disclosure that we have made of your health information. All of these rights are subject to some exceptions that are described fully in the Notice of Health Information Practice.

OUR OBLIGATIONS

We are required to provide you with our Notice of Privacy Practices and to abide by its terms. We may amend the Notice from time to time. All amendments apply retroactively. If you have any questions or require additional information, please contact our Practice Manager at 603-742-5556.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have received a copy of the Summary of Health Information Practice. This notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the notice may be changed at any time. I may obtain a revised copy of the notice by calling 603-742-5556 or by requesting one at the office.

_____

(PLEASE PRINT YOUR FULL NAME)

_____

(SIGNATURE) (DATE)

As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

_____

(SIGNATURE) (DATE)

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DERMATOLOGY AND SKIN HEALTH FINANCIAL POLICY

If you have medical insurance we will be happy to bill most insurance companies if you provide our office with all of the necessary information. Any balance, however, is ultimately your responsibility. Your co-payment is due at the time of your visit. We accept cash, checks, credit cards, and online payments.

MEDICAL INSURANCE:

We participate with the folowing major insurances: Blue Cross Blue Shield, Harvard Pilgrim, Cigna, Medicare, Aetna, Medicaid, Health Plans Inc., Tufts, United Healthcare, Martins Point, Tricare, and other smaller insurances. Please call the office with questions.

For other insurance companies that we do not participate with, we will make a reasonable effort to bill. However, there may not be any benefits or there may be limited benefits for services by our providers. Please be advised that it is your (the patient's or the insured's) responsibility to contact your insurance company to see what your plan covers prior to treatment. In cases of liabilty, we do not bill third party insurances, attorneys or workers comp; payment in full is expected at the time of your visit.

If your insurance has not paid within 60 days, the balance will become your responsibility and we recommend that you contact your insurance company.

Cosmetic services are never billed to Medicare or any insurance carrier.

MANAGED CARE INSURANCES:

As a specialty practice, our providers are not authorized to provide services for patients with managed care insurance without authorization from their primary care physician. The exception to this would be if your insurance includes a Point of Service Plan or a Preferred Provider Organization, which allows you to choose treatment without a referral. For al other HMOs, please be advised that it is your responsibility to make certain a referral authorization has been received in our office prior to your appointment or that you bring your referral with you at the time of your appointment. If you do not have the referral with you or the referral is not in our office the day of the appointment you will be responsible for any charges denied by your insurance for no referral.

ADDITIONAL INFORMATION:

You may receive two separate bills for pathology one for the technical component and one for the professional components.

Our office does provide 24 hour emergency call coverage. Please call our answering service at 866-677-2985 and they will contact the provider on call.

In cases of divorced or separated parents, our policy is that the parent bringing the child into our office for services is responsible for any balance.

I hereby authorize Dermatology & Skin Health to furnish my health information for purposes related to treatment, payment, and health care operations and hereby assign to Dermatology & Skin Health all payments for medical services rendered. I understand and agree that, regardless of my insurance status, I am ultimately responsible for my balances due and/or collection fees if applicable. I have read the information in this policy and verify that all insurance information is true and correct to the best of my knowledge.

I hereby agree to consultation with Dermatology & Skin Health and agreed upon treatment. I understand that this signature is valid for any treatment for the duration of one year.

(SIGNATURE) (DATE)