DERMATOLOGY & SKIN HEALTH
784 CENTRAL AVENUE DOVER, NH 03820 (603) 742-5556

Gary W. Mendese, MD, FAAD E. Niki Bryn, ARNP, DCNP Stephen D. Moyer, DO, FAAD
Michelle M. Roy, PA-C Tara Delle Chiaie, APRN

Please Complete All Items. Please Print Clearly.

PATIENT INFORMATION

NAME_____
LAST FIRST MIDDLE INITIAL

MAILING ADDRESS_____

CITY_____STATE_____ZIP_____

D.O.B___/___/_____SEX_____MARITAL STATUS_____SSN_____-_____-_____

HOME PHONE (___) _____-_____ WORK PHONE (_____) _____-_____

CELL PHONE (_____) _____-_____ E-MAIL ADDRESS_____

PRIMARY CARE DOCTOR_____

EMERGENCY CONTACT_____
NAME PHONE NUMBER RELATIONSHIP

MAY WE SHARE MEDICAL INFORMATION WITH THIS PERSON? YES NO

INSURANCE POLICY HOLDER INFORMATION

PRIMARY INSURANCE COMPANY_____

SUBSCRIBER NAME_____
LAST FIRST MIDDLE INITIAL

D.O.B___/___/_____SEX_____SSN_____-_____-_____

RELATIONSHIP TO PATIENT_____

SECONDARY INSURANCE COMPANY_____

SUBSCRIBER NAME_____
LAST FIRST MIDDLE INITIAL

D.O.B___/___/_____SEX_____SSN_____-_____-_____

RELATIONSHIP TO PATIENT_____

**Please bring your insurance cards and a photo ID with you to your appointment.

***Insurance policy holder DOB and SSN is required for billing purposes. Information will not be shared. Thank you.*

Dermatology & Skin Health
784 Central Avenue Dover, NH 03820
ph 603-742-5556 fax 603-742-8668

Directions

Our office is across the street from Wentworth-Douglass Hospital.

Take **Exit 9** off the Spaulding Turnpike; **take a right off the exit.**
At the major intersection of Five Guys restaurant and Chili's restaurant **take a right onto Central Avenue (Route 108)**.

Count 4 lights, **the first** is at Fiddlehead Farms on the right, the **2nd** at Dunkin Donuts on the right, the **3rd** at Shaw's Plaza on the left, and the **4th** at Hannaford's on the left. You will be taking the second street on the right after the fourth set of lights.

You will pass the EMERGENCY entrance to Wentworth-Douglass Hospital on the left. On the right will be Lowell Avenue and then Abbott Street. **(We are located on the corner of Central Avenue and Abbott Street).**

Take a right onto **Abbott Street** and park behind the building in our parking lot. For those that need **handicap parking, please use the Abbott Street entrance.** If this lot is full there is additional parking just beyond our building via Central Avenue on the right. When looking at our building this lot is to the left of our building. From this side lot you must come upstairs for Dermatology.

The building is red brick and the sign reads **DERMATOLOGY & SKIN HEALTH** on the front.

DERMATOLOGY & SKIN HEALTH
784 CENTRAL AVE, DOVER, NH 03820
603-742-5556

History and Intake Form

Patient's Name_____**Date of Birth**_____

Race_____**Ethnicity**_____

Reason for Visit_____**Visit Date**_____

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
Other_____

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

TWO SIDED DOCUMENT – PLEASE COMPLETE BOTH SIDES

Skin Disease History: (please circle all that apply)

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

Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Family History:
Family history of: Melanoma? No Yes If yes, Who?_____
Basal Cell Carcinoma? No Yes Who?_____
Squamous Cell Carcinoma? No Yes Who?_____

Social History: (Please circle all that apply)
Cigarette Smoking:

Never smoked	Quit: former smoker
Smokes less than daily	Smokes daily

Do you ever consume alcohol? Yes No
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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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, and credit cards.

MEDICAL INSURANCE:

We participate with the following insurances: Blue Cross Blue Shield, Harvard Pilgrim, Cigna, Medicare, Aetna, Medicaid, Health Plans Inc., HCVM, United Healthcare, Martins Point and MVP.

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 liability, we do not bill third party insurances or attorneys; 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 all 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 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 not provide 24-hour emergency call coverage. If you have a medical emergency after office hours please go to the closest emergency room.

In cases of divorced or separated parents, our policy if that the parent bringing the child into our office for services must be 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 account for any services rendered. 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.

DATE SIGNATURE OF PATIENT OR REPRESENTATIVE RELATIONSHIP

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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 described 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 from 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 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)