DSH
Dermatology & Skin Health

New Patient Intake Packet

Please Complete All Items & 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: _____
First Last Middle Initial

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

Member ID: _____ **Group Number:** _____

Subscriber Number: _____

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Subscriber D.O.B. _____/_____/_____ **Subscriber sex:** _____

Relationship to Patient: _____

Secondary Insurance Company: _____

Subscriber Name: _____
First Last Middle Initial

Member ID: _____ **Group Number:** _____

Subscriber Number: _____

Subscriber D.O.B. _____/_____/_____ **Subscriber sex:** _____

**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.

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Directions to Our Offices

Directions to Dover Office: 784 Central Ave. Dover, NH

Take Exit 9 off of NH-16 North. Take Central Ave to your destination. 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. If you need handicapped parking please use the Abbott St. entrance.

Directions to Dover (South) Office: 15 Durham Rd. Dover, NH

Take NH-16 to Exit 7. Turn onto NH-108 S/Durham Road. Destination will be on your right. We are located on the 2nd floor of the medical building.

Directions to Portsmouth Office: 2299 Woodbury Ave. Portsmouth, 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.

Directions to Derry Office: 6 Tsienneto Rd. Derry, NH

Take I-93 to Exit 4. Continue to NH-102 E/Nashua Rd in Londonderry. Continue on NH-102 E, take N High St to Tsienneto Rd in Derry. Enter Overlook Medical Park. We are located on the 2nd floor of the medical building.

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Directions to Peabody Office: 23 Centennial Dr. Peabody, MA

Take I-95 toward Peabody. Take Exit 38 toward Centennial Drive. Turn into 23 Centennial Drive. We are located on the back side of the building facing Summit Street.

Directions to Nashua Office: 76 Allds Street Nashua, NH

Take Route 3 South, (The Everett Turnpike) to Exit #4 (East Dunstable Road) in Nashua. Turn left at end of exit ramp onto East Dunstable Rd. Continue on East Dunstable Rd. until you approach the traffic lights at Main Street. Turn left onto Main Street. Merchants Car Rental is on the right-hand side, turn right, this is Allds Street. Continue to a traffic light and proceed forward. A little beyond this point, on the left, you will see two brick office buildings. We are the 2nd office building (#76). Parking is in the rear of the building and our office is on the first floor.

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

Past Surgical History: (please circle all that apply, cont'd below)	
Appendix Removed	Kidney Biopsy
Tonsils Removed	Kidney Removed (Right, Left)
Bladder Removed	Kidney Stone Removal
Mastectomy (Right,Left, Bilateral)	Kidney Transplant

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Lumpectomy (Right, Left, Bilateral)	Ovaries Removed
Breast Biopsy (Right, Left, Bilateral)	Pacemaker
Colectomy	Prostate Removed
Gallbladder Removed	Prostate Biopsy
Coronary Artery Bypass	TURP
PTCA	Skin Biopsy
Valve Replacement	Basal Cell Carcinoma Surgery
Heart Transplant	Squamous Cell Carcinoma Surgery
Joint Replacement, Knee (Right, Left, Bilateral)	Melanoma Surgery
Joint Replacement, Hip (Right, Left, Bilateral)	Spleen Removed
Joint Replacement within last 2 years	Other: _____
Testicles Removed (Right, Left, Bilateral)	_____

Patient of Childbearing Potential: (please circle all that apply)
Pregnant
Breastfeeding
Trying to get pregnant

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? _____ Y _____ N If yes, what SPF? _____	

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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

Alcohol:

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

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.

_____

(**Printed Full Name**)

_____

(**Signature**) (**Date**)

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

_____

(**Signature**) (**Date**)

Dermatology & 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**)

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Late Policy

Effective 10/01/23, We are instituting a late policy for our practice to serve our patients better. If you arrive later than 10 or more minutes past your scheduled appointment. You will be asked to reschedule your appointment. A front desk team member will happily assist you in finding the next available appointment slot. Please understand that this policy ensures that our providers and staff have enough time to address all your concerns during your visit. We thank you for your cooperation.

By signing below, you acknowledge your understanding and willingness to comply with this policy. You will be asked to renew this policy annually on the first business day in October.

_____

(**Printed Full Name**) (**Date**)

_____

(**Signature**)

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Parental Pre-Authorization for Medical Care to Children

For families who are ongoing patients of Dermatology & Skin Health, it may be more convenient to have prior authorization for medical care delivered to minors without a parent having to be present prior to treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment in advance.

AUTHORIZATION

I (we) request and authorize Dermatology & Skin Health and its personnel to deliver medical care to my (our) child listed below:

PLEASE PRINT:

Name: _____ **D.O.B.** _____/_____/_____

You may try to contact me (us) regarding the health of my (our) child at the following number(s):

Parent's Name: _____

Phone (office/home): _____

Parent's Name: _____

Phone (office/home): _____

Other (relationship): _____

Phone (office/home): _____

Signature: _____ **Date:** _____

DSH Patient Care Contract

What all DSH staff members honor to provide during your appointment:

- Treat you (the patient) with respect.
- Will address your concerns during the appointment time.
- Will ensure that you are treated with the utmost care during your visit.
- Our staff will make sure that you are comfortable, cared for, and provided with a safe and clean clinic environment.

I, _____ , understand and agree to adhere the following:
(Patient Name/ Representative):

We at DSH ask the following of you the patient:

- I will keep (and be on time for) all my scheduled appointments at Dermatology & Skin Health (DSH) in accordance with the DSH Late Policy.
- I will always treat all staff at DSH respectfully. I understand that if I am disrespectful to staff or disrupt the care of other patients, I may be asked to leave the premises and my care plan at DSH may be terminated at the discretion of DSH management. Examples of disrespectful behavior is as follows:
    - Use of foul language
    - Verbal, Emotional, or Physical abuse of staff
    - Use of sexual references
    - Threatening behavior verbal or physical
- I will not talk on my cell phone when in the lobby or when in an examination room.
- I will not smoke, vape, use any drugs, or alcohol on any DSH office premises.
- I will not bring any weapon or item that could be used as a weapon on any DSH premises.
- I will be cognizant of the staff's time after the concerns stated during my appointment have been addressed.
- I will keep up to date with any bills from the office per the DSH financial policy. I will notify the front team if my insurance has changed, or form of payment has changed.

This form will be renewed yearly on or after the first business day in October. By signing below, you are acknowledging your understanding and willingness to comply with the terms outlined above. If you (the patient or representative) do not comply with the terms outlined above as determined by DSH staff, you may be terminated as a patient of DSH, at the discretion of DSH management.

Date | Signature of patient or representative | Relationship