Dear Patient,

We welcome you to Stony Brook Dermatology Associates. It is important not to rush through these forms since important (requested) data such as your medical history must be accurate and thorough. If you are unsure of any section, leave it blank and we will assist you when you arrive.

Please remember to bring your completed forms, your insurance card so that we can scan it into your electronic medical record and your referral (if applicable). Insurance referrals authorize payment for medical services & if you are insured with a carrier that requires one, it is your responsibility to obtain it & confirm that it has either been submitted electronically by your primary care physician (PCP) and or received in the office. If you need the ID# for the dermatologist you will be seeing here, we are more than happy to provide you with the information you need to ease the process. All (paper) referrals should be sent to fax# 631-638-4220.

_We respectfully request a minimum 24hr. advance notice if you need to cancel or reschedule your appointment to avoid incurring a “No Show” fee._ We understand that you may have changes to your own schedule however, our goal is to maximize appointment availability to ensure that all patients on our wait list can avail themselves of unexpected appointment openings.

If you have any questions prior to your visit, please feel free to contact us @ 631-444-4200 and we will be happy to assist you.

Sincerely,

Julie Bouziotis
Practice Manager
Directions to our office can be obtained by calling our main number @ 631-444-4200 and pressing option 4.

- **From the LIE (Long Island Expressway)** take exit 62 and follow signs for Route 97 N Nicolls Road. Continue on Nicolls Road to Route 347 (Nesconset Highway) and make a right. At the 3rd traffic light make a left onto Belle Mead Rd. You will be entering Technology Park. Continue on Belle Mead Rd. to #181 & turn right into the parking lot.

- **From the NS (Northern State Parkway)** please follow it to the end & follow signs for Route 347 (Nesconset Highway). Cross over Nicolls Road and make a left at the 3rd traffic light onto Belle Mead Rd. You will be entering Technology Park. Continue on Belle Mead Rd. to #181 & turn right into the parking lot.

- **From Route 347 (Nesconset Highway) traveling West** make a Right onto Belle Mead Rd. You will be entering Technology Park. Continue on Belle Mead Rd. to #181 & turn right into the parking lot.

- **From Route 347 (Nesconset Highway) traveling East** you will cross over Nicolls Rd. & make a left onto Belle Mead Rd. which is the 3rd traffic light. You will be entering Technology Park. Continue on Belle Mead Rd. to #181 & turn right into the parking lot.

- **From 25A traveling East** make a Right onto Nicolls Rd. traveling South and continue to Route 347 (Nesconset Highway) and make a Left. At the 3rd traffic light make a Left onto Belle Mead Rd. You will be entering Technology Park. Continue on Belle Mead Rd. to #181 & turn right into the parking lot.

- **From 25A traveling West** make a Left onto Nicolls Rd. traveling South and continue to Route 347 (Nesconset Highway) and make a Left. At the 3rd traffic light make a Left onto Belle Mead Rd. You will be entering Technology Park. Continue on Belle Mead Rd. to #181 & turn right into the parking lot.
NEW PATIENT PAPERWORK PACKAGE “CHEAT SHEET”

Page 1: **E-Prescribing Consent Form**
- Please only list known DRUG allergies. If none know indicate N/A
- Enough pharmacy information for us to locate & identify correctly on google search

Page 2: **Communication Consent** – Patient approval regarding private health information (HIPAA)

Page 3: **Ambulatory Care Consent Form**

This form is requesting your consent to receive care in our outpatient facility as well as your confirmation of receipt of our notice of privacy practices
- Please write in your name & D/O/B
- Sign on the 1st signature line IF you are the patient or patient representative
- Indicate your relationship IF you are NOT the patient who has signed
- Please write in the date

Page 4-5. **Agreement for Physician Practices** (Billing & HIPAA consents)

Page 6: **Ambulatory Care Summary List**

This is to be complete by the patient or patient’s guardian. This provides your doctor with medical history & clinical information that becomes part of your medical record (4 separate & distinct categories)

<table>
<thead>
<tr>
<th>Allergies/Medical Conditions/Past Procedures/Medications</th>
</tr>
</thead>
</table>

In any section where there is no applicable information for you to enter, please write in “N/A” to indicate that this is not applicable

Remember that it’s important to provide any & all information within each category that is known to you

Page 7: **Related Historical Information Sheet/Primary Care Physician & HIPAA information**

PLEASE write your name on top
- These are a series of Yes & No questions – please answer ALL
- Please complete current PCP & Referring physician information
- Don’t forget to answer the permission to discuss your medical condition (HIPAA) question @ the bottom
- Do NOT forget to sign @ the bottom!

Page 8: **Adult Patient Needs Assessment**

It is critical that this be completed in its entirety to ensure that we plan proper accommodations if needed. **IF** the patient is a child, the following sections apply to his/her guardian:
- Communication
- Culture
- Learning Preference
- Domestic Concerns

**Falls Risk & Nutrition Screen** applies to the child/patient
E-Prescribing Consent Form

Patient’s Name __________________________________________ Date of Birth: ____________________

Stony Brook Dermatology Associates, UFPC is in the process of implementing e-Prescribe (electronic prescribing) in our ongoing efforts to maximize patient safety.

Total Quality in patient care is just one of our ongoing commitments...

Patient benefits:
• Less confusion over handwritten prescriptions or unclear phone calls
• Reduced possibility of medical errors
• Less chance of adverse drug reactions
• Fewer trips to drop off at the pharmacy
• A safer, faster & easier way to get your prescription filled

Please list any DRUG allergies:
________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________

Please provide our office with your pharmacy name(s), address & phone number so that we may enter this data into your medical record.

Pharmacy Name (1st Choice):
________________________________________________________
Street Name, Town OR ZIP CODE:
________________________________________________________
Ph#: __________ - __________ - __________ (if known)
Pharmacy Name (2nd Choice):
________________________________________________________
Street Name, Town OR ZIP CODE:
________________________________________________________
Ph#: __________ - __________ - __________ (if known)

Patient Consent:

I agree that Stony Brook Dermatology Associates, UFPC may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes. This consent form will be updated on an annual basis.

________________________________________________________
Patient Signature ___________________________ Date ___________________________
It is the policy of Stony Brook Dermatology not to release confidential information other than face to face without **authorization** to do so by alternative methods (Voice Mail/Answering Machine/Telephone). Any information that will be provided will be released only to the authorized person(s) listed below.

I authorize Stony Brook Dermatology, and/or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes (please fill out all contact information).

- **Home Telephone:** ______-______-______  YES ___ NO____
- **Answering Machine:**  YES ___ NO ___
- **Work Telephone:** ______-______-______  YES ___ NO ___
- **Cell/ Voice Mail:** ______-______-______  YES ___ NO ___
- **E-mail:** ___________________@_________.com  YES ___ NO ___
- **Regular Mail:**  YES ___ NO ___

If you would like to have information released to someone other than yourself, please complete the following list of authorized people:

- **Spouse:** ________________________________  Tel: ______-______-______
- **Adult Child:** ________________________________  Tel: ______-______-______
- **Other (please indicate relation):** _____________________  Tel: ______-______-______

**Print Patient Name:** __________________________  **Preferred Tel:** ______-______-______

**Patient Signature:** ___________________________
Ambulatory Care and/or Pre-Surgical Testing Consent

By signing below I consent to receive treatment and for the use and disclosure of my health information to provide treatment, arrange for my medical care, seek and receive payment for services provided to me and for the business operations of the Hospital and its staff.

I understand that with my permission, photographs/video and/or voice recordings may be taken of me and used for medical or scientific purpose such as documenting or planning my care, teaching or publication in a scientific journal. I understand that every attempt will be made to conceal my identity (name) prior to publication in a scientific journal or display of the photographs/video and/or voice recordings. I understand that the photographs/video and/or voice recordings taken to document my care may be a part of my medical record and those taken for other purposes may not be a part of my medical record.

I have been provided a copy of the SBOHCA Notice of Privacy Practices (Notice) on, or prior to this visit, and have therefore been advised of how health information about me may be used and disclosed by the Hospital and the facilities listed at the beginning of the Notice, and how I may obtain access to and control this information.

I acknowledge the receipt of the Ambulatory Care Patient Guide on, or prior to this visit.

I understand this authorization, for the use and disclosure of my health information to provide treatment, arrange for my medical care, seek and receive payment for services provided to me and for the business operations of the Hospital and its staff, may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in 12 months from the date signed.

I also understand I may refuse to sign this form and that my health care and payment will not be affected. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I may request a copy of this form after signing.

Signature of Patient or Patient Representative [Signature] Date [Date] Time [Time]

Print Name of Patient or Personal Representative [Print Name] Date [Date] Time [Time]

Relationship, if signed by person other than Patient [Relationship] Date [Date] Time [Time]

Signature of Witness [Signature] Print Name of Witness [Print Name]

Date [Date] Time [Time]

SPANISH.VER.:AD2C037ST

AD2C034 (5/14)
AGREEMENTS FOR PHYSICIAN PRACTICES

Financial Agreement / Guarantee of Payment: I, the undersigned patient or responsible party, agree to be fully responsible for payment to Stony Brook University Hospital / University Faculty Practice Corporations for the care and treatment of the patient whose name appears on this form. I understand that this includes cost sharing payments to the provider (including any copayments and deductibles) for care and treatment as required by the patient’s health insurance contract and benefits. I understand that the patient is responsible for ensuring that authorizations and approvals are obtained as required by their insurance company. If prior approval is not obtained when required or authorization has been denied, I am fully responsible for all charges that the insurance company does not pay, as may be specified under the provisions of my contract and the extent permitted by law. I understand that I am responsible to provide accurate information to the provider regarding: contact, demographic, health insurance and other pertinent information required for hospital / professional billing and that I must promptly notify the provider of any changes in this information. I agree to provide any other information reasonably requested by the provider in order to bill for the care and treatment provided. I understand that if I have any questions about my bills I may call:

- 631-444-4151 for Patient Accounts/ Hospital Billing.
- 631-444-4800 for Physician Services

Release of Information: I consent to the release of all or part of my health record, including my social security number to insurance carriers, government agencies, and other third party payors as needed in order for Stony Brook University Hospital/University Faculty Practice Corporations to obtain reimbursement for my care. I also understand that my social security number may be provided to the New York Department of Health in accordance with incidence reporting and other New York State hospital regulatory requirements and to manufacturers of medical devices and the Federal Food and Drug Administration for medical device tracking purposes. I consent to the use and disclosure of my protected health information as necessary to treat my condition, obtain payment for treatment and conduct health care operations.

Release of Information to Primary Care Provider & Uniform Assignment

Release of Information to Primary Care Provider: I authorize Stony Brook University Hospital, its Emergency Department, and University Faculty Practice Corporations staff to disclose the health care related information for this Emergency Department encounter to my Primary Care Practitioner (PCP) for the purpose of continuity of my health care. I understand that this will include information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection.

Uniform Assignment: I transfer, assign and set over to Stony Brook University Hospital/University Faculty Practice Corporations, sufficient monies and or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my hospitalization and medical care to cover the costs and treatment rendered to myself or my dependent.
 AGREEMENTS FOR
PHYSICIAN PRACTICES

The following section ONLY pertains to Medicare patients. Patients signing this form who have Medicare Benefits understand that this information is included for their signature.

MEDICARE

Medicare Assignment of Benefits: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers, any information needed for this or any related Medicare Claim. I request that payment of authorized benefits be made on my behalf directly to physician or organization providing medical care. I assign, transfer and set over all benefits payable for physician services to the physician or organization to submit a claim to Medicare for payment to me.
AMBULATORY CARE SUMMARY LIST

Pt. Name: ______________________________
M.R.#: ________________________________
D.O.B.: ______________________________
Phone (h) ____________________________
     (c) ____________________________
     (w) ____________________________

Ambulatory Care Guide Given □ (date) ____________
Advanced Directive Documents Received from Patient □ (date) ____________

<table>
<thead>
<tr>
<th>Allergies / Adverse Reactions (Describe)</th>
<th>□ No Known Allergies</th>
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<tbody>
<tr>
<td>Allergy</td>
<td>Description</td>
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<tr>
<td>____________________________</td>
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</table>

Diagnoses / Medical Conditions

<table>
<thead>
<tr>
<th>DATE</th>
<th>DATE RESOLVED</th>
<th>DATE</th>
<th>DATE RESOLVED</th>
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<tr>
<td>Heart valve problems such as MVP? Yes No</td>
<td>Do you need antibiotic prophylaxis? Yes No</td>
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<tr>
<td>Artificial joints? Yes No</td>
<td>If yes, please list__________________________________</td>
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<tr>
<td>Hepatitis? Yes No</td>
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<tr>
<td>Pacemaker/Defibrillator? Yes No</td>
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Past Operative / Invasive Procedures

<table>
<thead>
<tr>
<th>Past Operative / Invasive Procedure</th>
<th>Date</th>
<th>Past Operative / Invasive Procedure</th>
<th>Date</th>
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</table>

Medications (prescribed for or used by the patient)

<table>
<thead>
<tr>
<th>Start Date</th>
<th>Medication Name</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>Stop Date</th>
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**Stony Brook Dermatology Associates Registration Form**

**Name:**

```
Last  First  MI  Suffix
__________  __________  __________  __________
```

☐ Mr.  ☐ Mrs.  ☐ Ms.  ☐ Miss  ☐ Dr

**Address:**

```
Street #  Street Name  Apt#
__________  __________  __________
```

**City**  **State**  **Zip**

**Home Phone:** ________-________-________  **Cell phone:** ________-________-________  **Email address:** _________________________

**Social Security #:** __________-________-________  **Employer:** ___________________________

**Primary Insurance:** ___________________________  **ID#:** ___________________________  **Referral Required?**  Y  N

**FAMILY HISTORY:**  Please indicate if there is a family history of any skin conditions or cancers  Y  N

**Relationship to you – Father/Mother/Sister/Brother/Other:** ___________________________

**MEDICAL HISTORY:** Please circle yes or no if you have or have had any of the following:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Breathing Problems</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Thyroid Disease</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Prostate Disorder</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Liver Disorder</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Stomach/Intestinal Disorder</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Ear or Eye Disorder</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Joint Pain</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>HIV/AIDS</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Stroke</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Cancer</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Skin Cancer</td>
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<tr>
<td>Any Skin Disease</td>
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</tr>
<tr>
<td>Psychiatric Condition</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>Seizures</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Weight Loss</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Bleeding Disorder</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Migraines</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Other</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

Please indicate:

<table>
<thead>
<tr>
<th>Height:</th>
<th>Weight:</th>
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<tbody>
<tr>
<td>_______</td>
<td>_______</td>
</tr>
</tbody>
</table>

**SOCIAL HISTORY:**

1. Do you use Tobacco  Y  N  If yes, how much____________________
2. Do you use Alcohol   Y  N  Social  Weekends  Daily  (please circle)
3. Occupation _____________  4. SINGLE  MARRIED  DIVORCED  WIDOWED (please circle)

**Females only:**

**Primary/Family Physician Name & Address**

________________________________________

**Referring Physician Name & Address**

________________________________________

**Phone #:** ____________________________  **Phone #:** ____________________________

________________________________________  **DATE:** _______/_____/_______

**PATIENT (OR GUARDIANS) SIGNATURE**
Communication:
Do any of the following apply to you?
☐ Impaired Vision
☐ Impaired Hearing
☐ Reading or Speaking Problems
☐ Pain
☐ Concerns about your illness
☐ None of the above
☐ Other ______________________________

What is your primary language? _________________________

Do you have difficulty understanding English? ☐ Yes ☐ No
Can you read English? ☐ Yes ☐ No

What language do you prefer when receiving information? _________________________

Culture:
Do you have any Cultural/ Religious/ Spiritual Practices that are important for us to know to provide your health care?
☐ Yes ☐ No If Yes, please describe__________________________

Learning Preference:
How do you prefer to learn?
☐ Reading ☐ Person explaining to me ☐ Seeing/pictures ☐ Demonstration ☐ Video/Television

Is there anyone you would like to have with you during your teaching? If so, whom? _________________________

Domestic Concerns:
Have you been a victim of mental or physical abuse? ☐ Yes ☐ No
Do you feel that you are currently in danger at home? ☐ Yes ☐ No

Falls Risk:
Do you have a fear of falling? ☐ Yes ☐ No
Have you fallen in the last 12 months? ☐ Yes ☐ No

If you answered “YES” to either of these two questions, please notify staff immediately.

Nutrition Screen:
Have you noticed a decrease in appetite within the last month? ☐ Yes ☐ No
Have you had an unexplained weight loss (over 10 lb.) over the past 3-6 months? ☐ Yes ☐ No

Please describe your appetite: ☐ Good ☐ Fair ☐ Poor ☐ Other _________________________

Patient/Designee Signature: ____________________________ Date: __________

Practitioner Signature: _______________________________ ID#: ___________ Date: _____ Time: _______