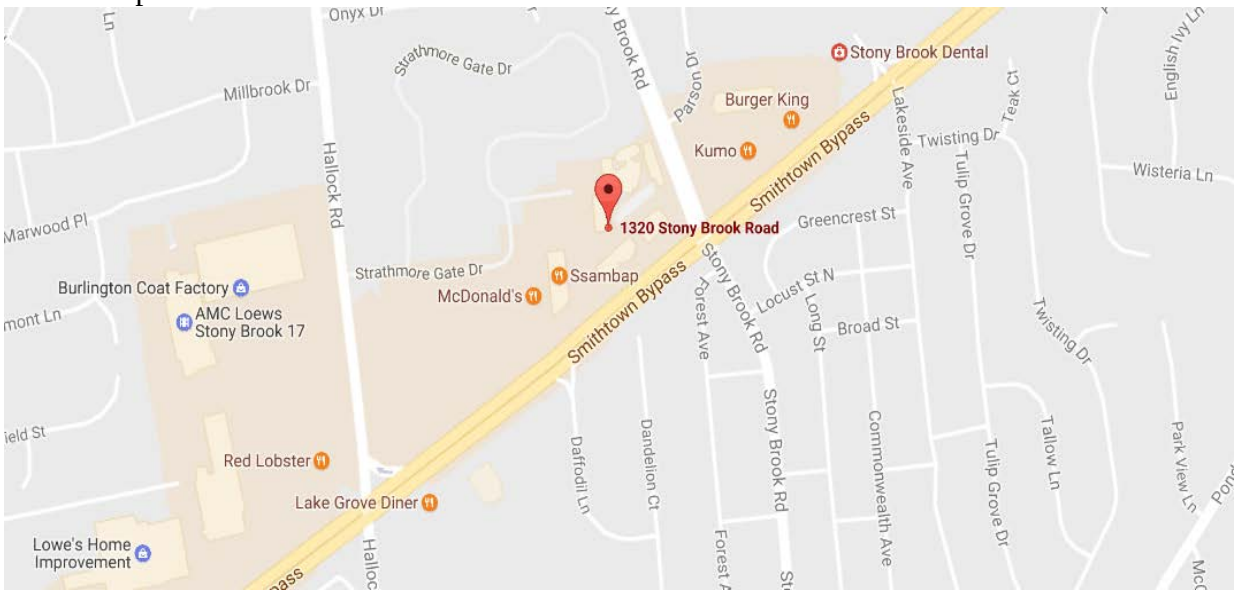
DIRECTIONS

1320 Stony Brook Road
Building F, Suite#200
Stony Brook, NY 11790

Directions to our office can be obtained by calling our main number @ 631-444-4200 and pressing option 5

Please note that there is another entrance on 347 Nesconset Highway (it is the 1st right turn after the traffic light at 347 Nesconset Highway & Stony Brook Rd.) traveling West. If traveling East, one would need to make a legal U-turn at this traffic light to access. Once you enter, make a right after the yield sign or go straight and loop around to access parking near Building F

- **From the LIE (Long Island Expressway)** take exit 62 North to Route 97/Nicolls Road. Stay on Nicolls Road for approximately 8 miles and turn left on Route 347/Nesconset Highway heading west. At the 2nd light turn right on Stony Brook Rd. and turn left into the shopping center either after Duane Reade or after Ralph's Italian Ices
- **From the NS (Northern State Parkway North)** take to the end & follow signs for Route 347 (Nesconset Highway) heading east for approximately 9 miles. Turn left on Stony Brook Road and turn left into the shopping center either after Duane Reade or after Ralph's Italian Ices
- **From Route 347 (Nesconset Highway) traveling West** turn right onto Stony Brook Road and turn left into the shopping center either after Duane Reade or after Ralph's Italian Ices
- **From Route 347 (Nesconset Highway) traveling East** turn left onto Stony Brook Road and turn left into the shopping center either after Duane Reade or after Ralph's Italian Ices
- **From 25A traveling East** turn right onto Stony Brook Road just before 347 (Nesconset Highway) and turn right into the shopping center either after Duane Reade or after Ralph's Italian Ices
- **From 25A traveling West** turn left onto Stony Brook Road just before 347 (Nesconset Highway) and turn right into the shopping center either after Duane Reade or after Ralph's Italian Ices



Name: _____ DOB: _____

STONY BROOK DERMATOLOGY ASSOCIATES

- REASON FOR VISIT: _____
- WEIGHT_____ HEIGHT_____
- ALLERGIES_____
- DO YOU FEEL WELL TODAY? YES ◯ NO ◯
  - If no what are your symptoms_____
- ARE YOU HAVING ANY PAIN? YES ◯ NO ◯
  - If yes, please tell us your pain level from 0-10 (0=none, 10 = worst)
  - What is your pain tolerance (threshold)?
- WHAT IS YOUR PRIMARY LANGUAGE?_____
- BARRIERS TO LEARNING: i.e.: impaired vision, hearing, reading or speaking YES ◯ NO ◯
  - If yes, please explain_____
- PATIENT/PARENT LEARNING PREFERENCES (Please check at least one)

☐ DEMONSTRATION ☐ EXPLANATION ☐ PRINTED MATERIALS ☐ VIDEO ☐ WEB BASED

- DO YOU PREFER SOMEONE PRESENT DURING TEACHING? YES ◯ NO ◯ WHO _____
- DO YOU HAVE CULTURAL/RELIGIOUS PRACTICES THAT AFFECT PROVISION OF YOUR HEALTHCARE? YES ◯ NO ◯ If yes please explain _____
- DO YOU HAVE TROUBLE WALKING OR STANDING? YES ◯ NO ◯
- HAVE YOU FALLEN IN THE PAST 12 MONTHS YES ◯ NO ◯
- DO YOU HAVE A FEAR OF FALLING YES ◯ NO ◯

WHEN WAS YOUR LAST INFLUENZA VACCINE?

Please list your MEDICATIONS or provide copy- If you need additional space please add to end of sheet. (If none, please indicate "none")

NAME	DOSE	HOW MANY TIMES A DAY TAKEN

Name: _____ DOB: _____

- DO YOU USE TOBACCO YES NO
- HAVE YOU EVER USED TOBACCO YES NO
- DO YOU USE ALCOHOL YES NO
  - How much_____
- DO YOU FEEL SAFE AT HOME YES NO

DO YOU HAVE A ***FAMILY*** HISTORY OF:

☐ MELANOMA Who/Type? _____

☐ OTHER TYPES OF SKIN CANCER Who/Type? _____

☐ ANY CANCERS Who/Type? _____

☐ Other skin diseases & Who/Type?_____

HAVE YOU EVER BEEN DIAGNOSED WITH MELANOMA? YES NO

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OTHER TYPE OF SKIN CANCER? YES NO

LIST ALL MEDICAL PROBLEMS (If none, please indicate "none")

_____

_____

_____

- Heart valve problems: Yes No
- Artificial joints: Yes No
- Hepatitis: Yes No
- Pacemaker/Defibrillator: Yes No
- Do you need antibiotics before procedures? Yes No

LIST ANY PROCEDURES (If none, please indicate "none")

_____

_____

_____

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

Name: _____ DOB: _____

COMMUNICATION CONSENT

STONY BROOK DERMATOLOGY
1320 Stony Brook Road
Building F, Suite #200
Stony Brook, NY 11790

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: _____ _____ 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: _____-_____-_____

Preferred Tel: _____-_____-_____

Patient Signature: _____ Date: _____

Clear Form E-mail Print