DIRECTIONS

500 Commack Road Suite#102
Commack, NY 11725

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

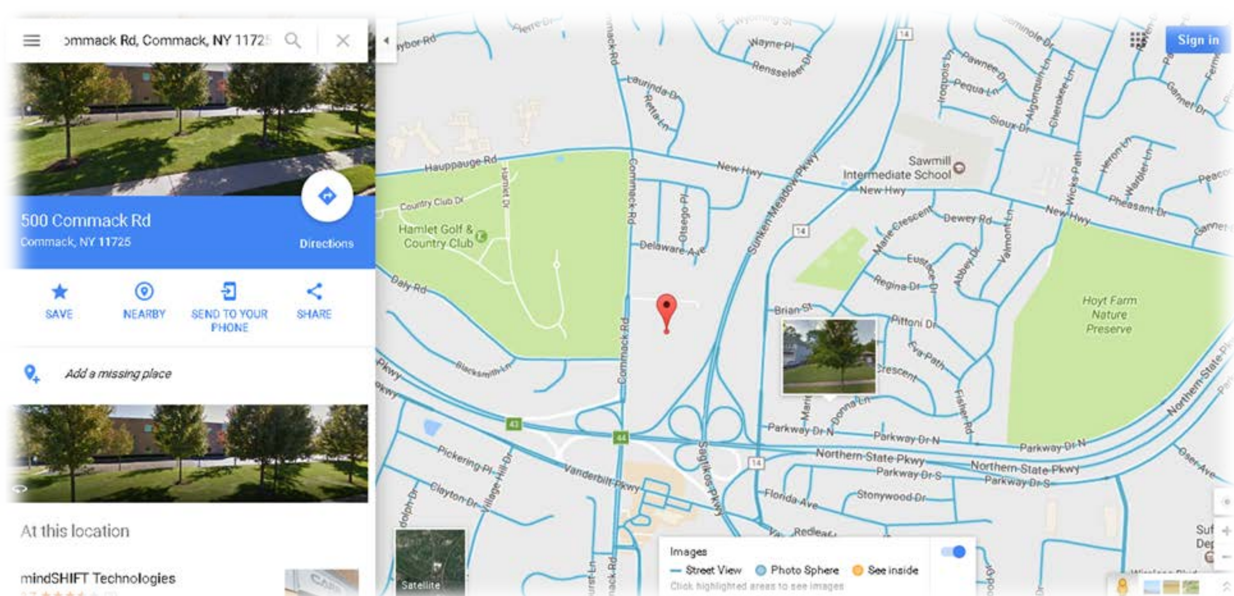
From the LIE (Long Island Expressway) take exit 53 toward Bayshore/Kings Park. Keep right to take the ramp towards Kings Park. Merge onto Sagtikos Parkway North. Take exit SM1W toward New York. Merge onto Northern State Parkway West. Take County Highway 4 exit 43 toward Commack. Turn left onto Commack Road and turn right into the parking lot by the Stony Brook street sign.

From the Northern State Parkway take to County Highway 4 exit 43 toward Commack. Turn left onto Commack Road and turn right into the parking lot by the Stony Brook street sign.

From 347 (Nesconset Highway) travelling West stay straight to go onto Northern State Parkway West. Take County Highway 4 exit 43 toward Commack. Turn left onto Commack Road and turn right into the parking lot by the Stony Brook street sign.

From Sunrise Highway take the Robert Moses Parkway ramp North. Take the exit towards East Islip. Keep left at the fork and merge onto Southern State Parkway East. Keep left to take Sagtikos Parkway North via exit 41A toward Kings Park. Take exit SM1W toward New York. Merge onto the Northern State Parkway West. Take the County Highway 4 exit 43 toward Commack. Turn left onto Commack Road and turn right into the parking lot by the Stony Brook street sign.

From Southern State Parkway take exit 41A Sagtikos Parkway North towards Kings Park. Take exit SM1W toward New York. Merge onto Northern State Parkway West. Take County Highway 4 exit 43 toward Commack. Turn left onto Commack Road and turn right into the parking lot by the Stony Brook street sign.



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

COMMUNICATION CONSENT

STONY BROOK DERMATOLOGY
500 Commack Rd
Suite 102
Commack, NY 11725

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: _______________________________