Today's Date_____

○ **Harold Farber, MD** ○ **Glenn B. Dempsey, MD**

Due to new requirements from the United States Department of Health and Human Services, we are requesting that all patients complete our Supplemental Patient Intake Form. We realize that some of the questions may be redundant and we request that your form be completed and reviewed periodically for any changes. We appreciate your patience and apologize for any inconvenience.

Patient's Name (PRINT):_____

Date of Birth: _____/_____/_____ **Age**: _____ **Sex: Male** ○ **Female** ○

We are continuing the process of building our Patient Portal to provide a communication option for our patients in compliance with Health and Human Service Requirements. Please provide a valid email address below:

(REQUIRED anyone 18 and older)_____@_____

Ethnicity: ○ Non-Hispanic ○ Hispanic

Language Preference: ○ English ○ Spanish ○ Russian ○ Other: _____

Race: ○ Caucasian or European American ○African or African American ○ Asian or Asian American
○ Native American or Native Alaskan ○ Native Hawaiian or Other Pacific Islander ○ Other

Smoking Status:
○ Not a current tobacco user
○ 0 Cigarettes per day (non-smoker or less than 100 in lifetime)
○ 0 Cigarettes per day (previous smoker)
○ Current Tobacco User
Please select the option that best describes your current tobacco use.
○ Few (1-3) cigarettes per day
○ Up to 1 pack per day
○ 1-2 packs per day
○ 2 or more packs per day

Do you take any prescription or non-prescription medications? Attach additional sheet if necessary.
○ **No** ○ **Yes (If yes please list)**

1_____ Dosage(s):_____ 2_____ Dosage(s):_____

3_____ Dosage(s):_____ 4 _____ Dosage(s):_____

5_____ Dosage(s):_____ 6 _____ Dosage(s):_____

Allergies to Medications?

○ **No** ○ **Yes (If yes please list)** _____

Location: ☐ **Skin** ☐ **Local** ☐ **Abdominal** ☐ **Systemic/Anaphylactic**

Reaction: _____

Severity: ☐ **Very Mild** ☐ **Mild** ☐ **Moderate** ☐ **Severe**

Onset: ☐ **Childhood** ☐ **Adult** ☐ **Unknown**

Please check if you have a history of the following:
○ High Cholesterol ○ Joint Replacement ○ Cancer _____
○Depression ○High Blood Pressure ○ Thyroid Condition
○ Diabetes ○ Skin Cancer ○ Asthma
○ Other_____

Signature:_____ **Date:** _____/_____/_____
(Parent or Guardian Signature if child is a minor)

Dermatology Medical History

Patient: _____ Date: ___/___/___

Reason for today's visit: _____

Are you allergic to any medications? ❑ YES ❑ NO If yes, list below:
1. _____ 2. _____

Have you ever had dental anesthesia (Novocaine)? ❑ YES ❑ NO Any bad reaction? ❑ YES ❑ NO

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):
1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	YES	NO
Bronchitis	❑	❑
Emphysema	❑	❑
Asthma	❑	❑
Chronic Cough	❑	❑
Morning Cough	❑	❑
Shortness of Breath	❑	❑
Wheezing	❑	❑

Cardiovascular:	YES	NO
High Blood Pressure	❑	❑
Chest Pain	❑	❑
Heart Attack	❑	❑
Heart Murmur	❑	❑
Irregular Heartbeat	❑	❑
Phlebitis	❑	❑
Inflammation of vein	❑	❑
Blood clots	❑	❑
Pacemaker	❑	❑

Other Systemic:	YES	NO
Diabetes	❑	❑
Excessive thirst/hunger	❑	❑
Thyroid	❑	❑
Kidney	❑	❑
Bladder	❑	❑
Frequency/burning	❑	❑
Gastrointestinal		
Stomach absorptive disorder	❑	❑
Nausea, vomiting, diarrhea when taking antibiotics	❑	❑
Yeast infection when taking antibiotics	❑	❑
Arthritis/Joint Deformity	❑	❑
Arthralgia	❑	❑
Limited motion	❑	❑
Artificial joint	❑	❑
Convulsions, Epilepsy or Seizures	❑	❑
Fainting	❑	❑

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin:

Have you ever had skin cancer? ❑ YES ❑ NO
Has anyone in your family had skin cancer? ❑ YES ❑ NO
Do you have a history of any specific skin diseases? ❑ YES ❑ NO If yes, _____
Do you have problems with healing ❑ YES ❑ NO
Do you develop keloids (scars) after surgery ❑ YES ❑ NO
Do you bleed easily? ❑ YES ❑ NO
Do you develop skin rashes in reaction to ❑ Medications ❑ Food ❑ Environment? _____

Social History:

Do you drink alcohol? ❑ YES ❑ NO If YES _____ drinks per day
Do you use IV drugs? ❑ YES ❑ NO If YES, what? _____ How often? _____
Do you smoke? ❑ YES ❑ NO If YES, how much: _____
Have you had or have you been exposed to HIV (AIDS) ? ❑ YES ❑ NO

Please answer the following questions:

(Women) Are you pregnant? ❑ YES ❑ NO Due Date: ___/___/___

What is your occupation? _____ Hobbies? _____

Completed by: ❑ Patient
❑ Medical Assistant _____ Initials

_____ Signed by Patient ___/___/___ Date

_____ Reviewed by ___/___/___ Date

Harold F. Farber, M.D.
Center for Dermatology, Laser & Cosmetic Surgery

PATIENT INFORMATION

Name: _____
Street Address: _____
Apt No: _____
City, State, Zip Code: _____
Home Phone: _____
Home Fax: _____
Sex: Male Female

Birth Date: _____
Social Security #: _____
Occupation: _____
Employer: _____
Work Phone: _____
Work Fax: _____
Cell Phone: _____

REASON(S) FOR VISIT: Cosmetic Medical Both
Is your visit work related?: NO YES Date of accident: _____
IF YES - ADDITIONAL DOCUMENTS ARE REQUIRED

Email Address: _____

YOUR FAMILY/REFERRING PHYSICIAN: _____
Your Primary/Referring Physician's Telephone: _____
YOUR PHARMACY: _____ **PHARMACY TELEPHONE #** _____
Your Pharmacy's Address _____
DO YOU HAVE INSURANCE FOR PRESCRIPTION DRUG YES NO

PRIMARY INSURANCE INFORMATION:
NAME: _____
ID # _____
GROUP # _____
Subscriber's Name: _____
Subscriber's Date of Birth: _____
Relationship to you: _____
Your specialist copayment: $_____
ARE YOU A FULL TIME STUDENT?: YES NO

SECONDARY INSURANCE INFORMATION:
NAME: _____
ID # _____
GROUP # _____
Subscriber's Name: _____
Subscriber's Date of Birth: _____
Relationship to you: _____
Your specialist copayment: $ _____

EMERGENCY CONTACT INFORMATION:
NAME: _____
HOME PHONE: _____
WORK PHONE _____
CELL PHONE: _____
FAX: _____

IF THE PATIENT IS A MINOR: RESPONSIBILE PARTY
NAME: _____
RELATIONSHIP TO PATIENT: _____
ADDRESS: _____
CITY, STATE, ZIP _____
HOME PHONE: _____
WORK PHONE: _____
CELL PHONE: _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIM(S) AND REQUEST PAYMENT OF ANY MEDICAL BENEFITS TO THE ABOVE NAMED PHYSICIAN FOR THE SERVICES RENDERED. ANY UNPAID BALANCE WILL BECOME MY RESPONSIBILITY AND I AGREE TO PAY SAID BALANCE WITHIN 30 DAYS OF THE PAYMENT NOTICE. IF THE PAYMENT IS NOT REMITTED WITHIN 30 DAYS, I UNDERSTAND THAT A LATE FEE WILL BE ACCESSED ON MY ACCOUNT. **PT INTIALS** _____

PLEASE SIGN YOUR FULL NAME: _____
PLEASE PRINT YOUR FULL NAME: _____
RELATIONSHIP TO PATIENT: _____ TODAY'S DATE: _____

10/26/2010

Center For Dermatology, Laser and Cosmetic Surgery, LLC
Harold F. Farber, M.D.
Diplomat, American Board of Dermatology

☐ 822 Montgomery Avenue, Suite 100 Narberth, PA 19072 **Tel** (610) 664-4433 **Fax** (610) 664-5290
☐ 9892 Bustleton Avenue, Suite 204 Philadelphia, PA 19115 **Tel** (215) 676-2464 **Fax** (215) 676-5536

Patient's Permission to release information to family member/representative

I _____ **DO/DO NOT** give permission to the Center For Dermatology,
Print
Laser and Cosmetic Surgery to release the following information to my designated contact and I that understand that it is my responsibility to notify this practice if or when I choose to change any of my designations.

☐ My Personal Medical Information, this includes but is not limited to test results, treatment plans and prescription information etc…to the individual(s) that I have identified below:

☐ My billing and insurance information, this includes but is not limited to dates of services, balances due from the insurance and/or patient, insurance carrier information, etc… to the individual(s) that I have identified below:

Name _____ Relationship to Patient _____
Print Print
Address: _____

Telephone#: _____

Name _____ Relationship to Patient _____
Print Print
Address: _____

Telephone#: _____

Patient Signature: _____ Date: _____
Signature

YOU MUST COMPLETE THIS FORM IF YOU WANT OUR OFFICE TO RELEASE YOUR INFORMATION TO A FAMILY MEMBER, FRIEND OR REPRESENTATIVE

HAROLD F. FARBER, M.D.
Diplomat, American Board of Dermatology

Dermatology, Laser & Cosmetic Surgery

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HEALTH INFORMATION PORTABILITY AND ACOUNTABILITY ACT HIPAA

PATIENT AUTHORIZATION

Must be signed and returned to office to be placed in patients charts. Patient agrees to the following:

1. Permit communication about health and personal information to another treating doctor – other than HIV records, psychological records, or drug and abuse records.
2. Permit communication about health and personal information, excluding those listed in item #1 to insurance companies.
3. Permit communication about health and personal information; excluding those listed in item #1 to a requesting attorney.
4. Permit communication about health and personal information to government authorities.
5. Permit messages to be left on voice mail for appointment reminders.
6. Permit messages to be left on voice mail with lab or xray results
7. Permit practice to release information to medical examiner or coroner to identify a deceased individual or identify cause of death.
8. Permit release of information to organ or tissue donor facilities, if you are an organ donor.
9. Permit release of information threatening your health, safety, or national security.
10. Permit release of information to Workman's Compensation or similar programs.
11. Permit patient statements to be mailed to me marked "Personal and Confidential"

I may revoke my consent, in writing, except to the extent that the practice has already made disclosures upon my prior consent. If I do not sign this consent Harold F. Farber, M.D. and Associates may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient Name (Please Print) Date

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FINANCIAL RESPONSIBLITY

I _____ acknowledge and understand
Patient name print

I parent/guardian/POA _____ for _____
Parent guardian/POA print Patient name - print

I am financially responsible and liable:

- To promptly pay this practice all co-payments, deductibles, coinsurance, cost share and balances for non-covered services that are deemed to be patient responsibility by my insurance.
- It is my responsibility to know, understand and review my insurance benefits and requirements that my insurance carrier sets for my medical coverage.
- That the practice physicians rendered medically necessary care, how my insurance carrier processes the charges issued to them by this practice is determined by my insurance coverage and level of available benefits. That I will be responsible to pay the practice for any balances my insurance carrier deems patient responsibility when their allowances are used to satisfy any patient deductibles, coinsurance, co-payments or cost shares.
- To notify this practice whenever my primary or secondary insurance coverage changes.
- To obtain referrals from my primary care physician when they are required by my insurance.
- That I will be liable to pay this practice for any services rendered when my employer cancels insurance coverage or due to my failure to pay insurance premium when my insurance carrier retroactively cancels my coverage.
- That I am responsible to contact my insurance carrier and respond to any and all their questionnaires related to my insurance coverage.
- That this practice accepts cash, check, money order, debit card, credit card and Care Credit for payment and that payment arrangements are offered for balances on a case-by-case basis.
- This practice is not a financial institution and we therefore expect payment in full for services rendered.
- This practice's Return check fee – for any reason is $30.00 in addition to my outstanding balance due.
- That I may receive separate billing notices from the laboratory responsible for processing any biopsy or specimens sent for pathology.

_____ Date _____ Witness: _____
Signature