RETURN COMPLETED FORMS: via FAX (646)218-4133 or via email kerisderm@gmail.com or via regular mail to address below

Initial Visit

Questionnaire

Keris Dermatology, PLLC
166 Fifth Avenue, 2nd Floor
New York, New York 10010

Date: ________________

____________________________________ Age:________ Birthdate:______________________
Patient's Name, First/Last Month/Date/Year

Patient's Social Security Number: __________________________ Sex: M_____ F_____

Parent/Guardian Name: ________________________________Marital Status: M____ S____ W____ D____
(If patient is a minor)

Address: ____ Home Phone: ______________________

City: ___________________ State: _________ Zip: ___________ Work Phone: ______________________

Email Address: ____ Cell Phone: ________________________

Occupation: Self: ______________________________ Spouse: ___________________________________

Referred by: Name: ____________________________ Phone: ____________________________________

Address: ____

Insured's Name: _________________________ Birthdate: ___________ Relationship: _________________

Who is the patient's primary Physician? Name: ____

Address: ____

Phone #: ____

Medicare # (include letter): ____
(if appropriate)

Primary/ Secondary Insurance Carrier: ____

Insured ID#: _________________________ Group#: ____

Pharmacy where prescriptions are filled____
(VERY IMPORTANT) (name, address, phone)

____

Note: Patients are responsible for fees at the time of treatment. We will, however, assist you in the proper processing of insurance forms.

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Patient Name: ____________________________________

1. HAVE YOU EVER HAD OR BEEN TREATED FOR ONE OF THE FOLLOWING?

1. Duodenal or peptic ulcer Yes No
2. Intestinal or stomach disease or colitis Yes No
3. Liver or gall bladder disease Yes No
4. Lung disease (tuberculosis, asthma, pneumonia) Yes No
5. Heart disease (murmur, rheumatic fever, pacemaker) Yes No
6. High blood pressure Yes No
7. Stroke____Yes No
8. Kidney disease Yes No
9. Urinary or bladder problem or infection Yes No
10. Venereal disease Yes No
11. Blood disorder or lymph gland disorder Yes No
12. Eye disease (glaucoma, cataract, cataract surgery) Yes No
13. Arthritis, joint problem or bone disease Yes No
14. Thrombophlebitis Yes No
15. Cancer/leukemia Yes No
16. Frequent infection (skin or other) Yes No
17. Neurological disorder Yes No
18. Emotional or psychiatric disorder Yes No
19. Are you HIV positive or have reason to believe you may be? Yes No
20. Do you have hepatitis or have reason to believe you may? Yes No

2. HAVE YOU OR ANY MEMBER OF YOUR FAMILY (SPECIFY WHO) EVER HAD:

1. Asthma Yes No
2. Hay fever Yes No
3. Eczema Yes No
4. Hives Yes No
5. Diabetes Yes No
6. Psoriasis Yes No
7. Skin cancer Yes No
8. Other skin condition Yes No

3. HAVE YOU EVER HAD:

1. Excessive bleeding when cut Yes No
2. Difficulty with healing of wounds Yes No
3. Overgrown scars or keloids Yes No
4. Allergy to local anesthetics Yes No
5. Do you have any pets? Yes No

Questionnaire

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Patient Name: ____

4. Have you previously had a skin problem or been under the care of a dermatologist? Yes No
(if yes, please describe) ____
____
____

5. Have you ever been given radiation therapy (x-ray treatments or Grenz ray treatment) to your skin?
Yes No (if yes, please explain) ____
____
____

6. Do you take any medicines, drugs, or over –the-counter prescriptions or remedies? Yes No
(if yes, please explain) ____
____
____

7. Are you allergic to any medicines, drugs, or over –the-counter prescriptions or remedies? Yes No
(if yes, please explain) ____
____
____

8.Prior hospitalizations and surgery (please give approximate dates and reasons): _______________
____
____

9. For female patients only:
1. Have you had vaginal yeast infection Yes No
2. Are you pregnant Yes No
3. Are you currently planning a pregnancy Yes No

Please inform the doctor at any time you plan to or become pregnant during your treatment.
I hereby authorize a physician of the Professional Practice Unit to examine (name)
And treat him/her as necessary. I understand that this is not a complete physical examination.

Signature: Date:

DERMATOLOGIC QUESTIONNAIRE

Are you concerned about (please check all that apply):

- ○ **Moles**
- ○ **Dry skin**
- ○ **Oily skin**
- ○ **Sensitive skin**
- ○ **Itchy skin**
- ○ **Excessive perspiration**
- ○ **Keloids**
- ○ **Razor bumps/ ingrown hairs**
- ○ **Red spots**
- ○ **Age spots/ liver spots**
- ○ **Uneven complexion**
- ○ **Wrinkles**
- ○ **Acne scars**
- ○ **Leg or facial veins**
- ○ **Red complexion**
- ○ **Dark spots**
- ○ **Unwanted hair**
- ○ **Laugh lines**
- ○ **Frown lines**
- ○ **Lip size**

Are you interested in learning about:

- ○ **Laser Hair removal**
- ○ **Botox**
- ○ **Restylane**
- ○ **Microdermabrasion**
- ○ **Chemical peels**
- ○ **Skin care products**

HEALTH HISTORY

Please answer the following questions by darkening the appropriate circles. Do not write anywhere else on the pages, because the doctor and staff will not see it. **CORRECT** **INCORRECT** **INCORRECT**

Social History

Marital status O married O single O widow/er O divorced

Do you use alcohol? O Yes O No

Do you smoke? O Yes O No

Have you had at least 1 blistering sunburn? O Yes O No

Do you use sunscreen? O always O sometimes O never

Do you use a tanning bed? O frequently O sometimes O never

Family History

Has anyone in your family had any of these conditions? You may select more than one.

Mother O asthma O hay fever O hives O diabetes

O psoriasis O skin cancer O other skin conditions

Father O asthma O hay fever O hives O diabetes

O psoriasis O skin cancer O other skin conditions

Siblings O asthma O hay fever O hives O diabetes

O psoriasis O skin cancer O other skin conditions

Children O asthma O hay fever O hives O diabetes

O psoriasis O skin cancer O other skin conditions

CONSTITUTIONAL

Do you currently have any of these conditions? Please choose yes or no.

Weight change O Yes O No Poor appetite O Yes O No

Fever O Yes O No Weakness O Yes O No

Breast feeding O Yes O No Formula feeding O Yes O No

Night sweats O Yes O No

Cold symptoms O Yes O No

Shortness of breath O Yes O No

Difficulty urinating O Yes O No

Depression O Yes O No

High stress level O Yes O No

Suicidal ideation O Yes O No

Eating disorder O Yes O No

Mental/phys. abuse O Yes O No

Obsessive-compulsive tendencies O Yes O No

Mood swings O Yes O No

Varicose veins O Yes O No

Leg swelling O Yes O No

Nausea O Yes O No

Vomiting O Yes O No

Muscle aches O Yes O No

Memory loss O Yes O No

Fatigue O Yes O No

Ear fullness O Yes O No

FINANCIAL AND FEEDBACK POLICIES

Keris Dermatology, PLLC
166 Fifth Ave., 2nd Flr.
New York, N.Y. 10010

Patient Name: ________________________________ **Date of Birth:** ___________

BASIC POLICY Payment for service is due in full at the time service is provided in our office.

FOR PATIENTS WITH INSURANCE We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

MEDICARE PATIENTS We will bill Medicare for you. We will also bill secondary insurance carriers for you. All copayments or deductibles are due and payable at the time service is provided.

MEDICAID PATIENTS We do not accept Medicaid. If you have supplemental coverage through Medicaid, you will be responsible for fees not covered by your primary insurance.

NONCOVERED SERVICES Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

MISSED APPOINTMENTS In fairness to other patients and the doctor, we require at least 24 hours' notice to cancel appointments. You will be charged $50 for missed appointments or dismissed from the practice.

DEDUCTIBLES You are responsible for determining whether you have met your yearly insurance deductible. If the deductible has not been paid prior to the date of service, all fees as determined by your insurance carrier, are due and payable in full from you.

REFERRALS You are responsible for determining whether a referral is needed for your office visit. If you fail to obtain a required referral all professional fees are due and payable in full from you.

FEEDBACK Billing concerns should be directed towards our billing department and will be promptly addressed. Any other concerns or grievances you may have should be addressed by speaking with our office manager, or sending us a letter via email, regular mail or fax. By signing below you agree to use the abovementioned mechanisms to express your feedback and that you will not publish your negative feed back and/or grievances on the internet. In the event that you do publish comments about or ratings of the practice that we determine to be damaging in any way, you agree to remove the comments and/ or ratings upon request within 48 hours.

I have read, understood, and agreed to the above financial policy for payment of professional fees and feedback policy.

The patient is ultimately responsible for all professional fees and for any legal fees incurred by the practice as a result of having to enforce these policies.

Signature: ____ Date: _____________________________