

**No Data Changes**  
 Staff Initial \_\_\_\_\_ Date \_\_\_\_\_  
 Patient Initial \_\_\_\_\_ Date \_\_\_\_\_  
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 Staff Initial \_\_\_\_\_ Date \_\_\_\_\_  
 Patient Initial \_\_\_\_\_ Date \_\_\_\_\_

Date: \_\_\_\_\_  
 Patient's Name: Mrs. Miss Ms Mr. Dr. \_\_\_\_\_  
 Address: \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
 Home Phone: ( ) \_\_\_\_\_ Business Phone: ( ) \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_ E-mail: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Referred by: \_\_\_\_\_ Address: \_\_\_\_\_  
 Allergies: \_\_\_\_\_ Medications: \_\_\_\_\_  
 Family Doctor: \_\_\_\_\_ Telephone \_\_\_\_\_  
 Can we call you at work? \_\_\_ No \_\_\_ Yes Please provide an authorized person/phone number who can receive your medical information in the case of an emergency \_\_\_\_\_

**Please answer all questions:**

1. Are you or your spouse currently employed? \_\_\_\_\_
2. Is your current illness/injury a result of an auto-accident or other injury? \_\_\_\_\_
3. Did your present illness occur at work? \_\_\_\_\_
4. Are you a full time student? \_\_\_\_\_

**Please answer all insurance questions completely:**

**Primary Insurance:** \_\_\_\_\_ **Please circle: HMO PPO POS Other**  
 Address of insurance: \_\_\_\_\_  
 Identification # \_\_\_\_\_ Group Number: \_\_\_\_\_  
 Insured's Name: \_\_\_\_\_ Insured's Social Security number: \_\_\_\_\_  
 Insured's date of birth: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ **Please circle: HMO PPO POS Other**  
 Address of secondary insurance: \_\_\_\_\_  
 Identification #: \_\_\_\_\_ Group Number: \_\_\_\_\_  
 Insured's Name: \_\_\_\_\_ Insured's Social Security Number: \_\_\_\_\_  
 Insured's date of birth: \_\_\_\_\_

**PATIENT FINANCIAL RESPONSIBILITY**

**I hereby assign my insurance benefits to be paid directly to the physician in this office. I hereby authorize the release of medical information related to the services received in this office.**

**If I do not have a valid referral for any visit as required by my insurance plan, I agree that I will be responsible for providing a valid referral within 48 hours of my visit. By signing below, I accept financial responsibility for all charges incurred at any visit if the appropriate referral is not received in the time specified or for non covered services performed.**

**JUVA has a policy to ensure the privacy of your medical information that is in concordance with the federal Health Insurance Portability and Accountability Act (HIPAA). You have the right as a patient of JUVA to receive a written or verbal explanation of the program to maintain confidentiality. I acknowledge that JUVA has given me a copy of its office privacy notice. I am aware of JUVA's policies and their patient bill of rights.**

**I request that payment of authorized Medicare benefits be made either to me or on my behalf to Bruce Katz, MD, Michael Bruck, MD, Kathryn Frew, MD, Michele Pauporte, MD, Marianne Pistilli, PA and/or Diane Maiwald, MD for services furnished to me by my provider. I authorize any holder of medical information about me to release to the Centers for Medicare and its agents any information needed to determine these benefits payable for related services.**

**I understand that if I do not cancel any of my appointments at least 24 hours before, I may be charged a cancellation fee.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Medical History

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Occupation \_\_\_\_\_  Single  Divorced

Birth Place: \_\_\_\_\_  Married  Widow(er)

Education: \_\_\_\_\_ Years High School \_\_\_\_\_ Years College \_\_\_\_\_ Years Post-Graduate

\*\*\*\*\*  
What medications are you now taking? (Include dose and frequency) \_\_\_\_\_  
\_\_\_\_\_

What cosmetics, soaps, hair & skin products do you use regularly? \_\_\_\_\_  
\_\_\_\_\_

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	CIRCLE ONE	IF YES, EXPLAIN
<u>Do you have any allergies to medications?</u>	No/Yes	_____
<u>Have you recently taken aspirin? Blood thinners?</u>	No/Yes	_____
<u>Any sinus, hay fever or asthma in your family?</u>	No/Yes	_____
<u>Do you have a personal or family history of skin Cancer or melanoma?</u>	No/Yes	_____
<u>Any trouble with healing? Keloid scars?</u>	No/Yes	_____
<u>Have you ever had liver problems or hepatitis?</u>	No/Yes	_____
<u>Do you have a pacemaker?</u>	No/Yes	_____
<u>Do you have high blood pressure?</u>	No/Yes	_____
<u>Do you have heart problems? Previous heart attack?</u>	No/Yes	_____
<u>Do you have any lung or breathing problems?</u>	No/Yes	_____
<u>Do you have any history of tuberculosis?</u>	No/Yes	_____
<u>Do you have fainting spells? Any seizures?</u>	No/Yes	_____
<u>Do you have diabetes? Low blood sugar?</u>	No/Yes	_____
<u>Have you ever been hospitalized?</u>	No/Yes	_____
<u>Have you ever had any cosmetic surgery?</u>	No/Yes	_____
<u>Have you ever had major surgery?</u>	No/Yes	_____
<u>Any serious illness or injuries in the past year?</u>	No/Yes	_____

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Are you using any type of herbal medication? (If yes, describe) \_\_\_\_\_

Woman – Menstrual History: Are you now having regular periods? If not, please explain. \_\_\_\_\_  
\_\_\_\_\_

Do you take Birth Control Pills? No/Yes \_\_\_\_\_ If yes, what brand? \_\_\_\_\_ How Long? \_\_\_\_\_  
Are you planning to become pregnant? No/Yes \_\_\_\_\_

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### CONSENT FOR TREATMENT

I hereby give my consent for medical examination and treatment. I consent to routine dermatological procedures such as skin biopsy, treatment with liquid nitrogen, or the removal of minor skin lesions. These procedures will be explained in detail before treatment.

Date \_\_\_\_\_ Signed \_\_\_\_\_