



THE DERMATOLOGY CENTER AT OLD BRIDGE

Jeffery Rapaport, M.D., P.A., F.A.A.D.
Diplomate, American Board Of Dermatology
Clinical Instructor,
Mount Sinai School of Medicine

3663 Route 9 North--Old Bridge, N.J. 08857
732-591-1700

JASON STABACK, P.A. - C, M.S.
Board Certified - Physician Assistant

Patient Information

Name (Mr., Mrs., Ms., Dr.) _____
Home Address _____ City _____ State _____ Zip _____
Mail Address _____ City _____ State _____ Zip _____
DOB _____ Age _____ SS# _____
Day Phone _____ Evening Phone _____ Employer Phone _____
Emergency Contact _____ Phone _____ E-mail Address _____

Name, Address, of Responsible Party (if other than Patient) _____

Relationship to Patient: _____

Employer Information

Name _____ Occupation _____
Street _____ City _____ State _____ Zip _____

How did you hear about us?

If referred by a physician, friend or Patient, please give full name and address. If from another source, please be specific, for example, yellow pages, article in The New York Times, television appearance, magazine article, etc.

Primary Care Physician

Name _____ Phone _____
Mail Address _____ City _____ State _____ Zip _____
Does your insurance require a referral? No _____ Yes _____ If yes, referred by _____

Please present all INSURANCE and / or MEDICARE cards and referral to receptionist when returning this form.

Primary Insurance of Subscriber (insured)

Insurance Carrier _____ Phone _____
Mail Address _____ City _____ State _____ Zip _____
Insurance ID # _____ Group # _____
Subscriber's Name _____ Subscriber's DOB _____
Patient's relationship to Subscriber _____

Secondary Insurance of Subscriber (insured)

Insurance Carrier _____ Phone _____
Mail Address _____ City _____ State _____ Zip _____
Insurance ID# _____ Group # _____
Subscriber's Name _____ Subscriber's DOB _____
Patient's relationship to Subscriber _____

I authorize Dr. Rapaport / Jason Staback to submit all claims on my behalf, I also authorize assignment of benefits directly to his office and release of any medical records requested by my insurance carrier(s). I also acknowledge that if payment is not received that I will be held responsible for the entire balance of the bill. I agree to be responsible for any collection and court costs should my account be turned over to an attorney or collection agency. I agree to pay \$20.00 for any returned check. I agree to be responsible for any charges not covered due to not obtaining a current and valid referral from my physician.

Signed _____ Date _____

(If patient under 18, parent or legal guardian must sign)

PATIENT HISTORY

This Information is Confidential and Protected by NJ State Law

Please answer all questions as best as you can.

Reason (s) for visit:

Problems

1. _____
2. _____
3. _____
4. _____

How long have you had these problems?..... Problem 1. _____ Problem 2. _____

Problem 3. _____ Problem 4. _____

What treatments have you been prescribed? Problem 1. _____ Problem 2. _____

Problem 3. _____ Problem 4. _____

What have you tried on your own? Problem 1. _____ Problem 2. _____

Problem 3. _____ Problem 4. _____

What makes problem(s) worse? Problem 1. _____ Problem 2. _____

Problem 3. _____ Problem 4. _____

What improves problem(s)? Problem 1. _____ Problem 2. _____

Problem 3. _____ Problem 4. _____

Do problem(s) vary with the season, time of day, heat, cold, food, other illness, or medication? YES _____ NO _____

If Yes, please explain: Problem 1. _____ Problem 2. _____

Problem 3. _____ Problem 4. _____

What do you feel may be the cause of each problem? Problem 1. _____ Problem 2. _____

Problem 3. _____ Problem 4. _____

Are you allergic to any medication? YES _____ NO _____

If Yes, please list: _____

What medication(s) are you presently taking? Please list ALL _____

List ALL hospital and surgical admissions with year(s): _____

Please complete the following:

	YES	NO
Are you pregnant or breast feeding?.....	_____	_____
Have you taken Aspirin, Motrin, or similar products in the last 2 weeks?.....	_____	_____
Do you have a nitroglycerin patch or pacemaker?.....	_____	_____
Do you now have any growths, moles, or warts on your body which are changing color, bleeds, pains, itches or worries you?.....	_____	_____
Do you take antibiotics before dental procedures?.....	_____	_____
Have you ever fainted with surgery or blood drawing?.....	_____	_____
Do you heal with difficulty or form raised scars?.....	_____	_____
Do you take oral contraceptives?	_____	_____
Have you eaten today, within the last 4 hours?.....	_____	_____

Kindly complete:

Do you, or any family member have, or have had any of these problems?

	Personal Presently		Personal Past History		Family History Member		
	YES	NO	YES	NO	YES	NO	WHOM
Frequent day or night urination	_____	_____	_____	_____	_____	_____	_____
Blood in urine or sperm	_____	_____	_____	_____	_____	_____	_____
Discharge from genitals	_____	_____	_____	_____	_____	_____	_____
Partner with sexually transmitted disease	_____	_____	_____	_____	_____	_____	_____
Abnormality of menstruation	_____	_____	_____	_____	_____	_____	_____
Painful intercourse	_____	_____	_____	_____	_____	_____	_____
Infertility	_____	_____	_____	_____	_____	_____	_____
History of syphilis	_____	_____	_____	_____	_____	_____	_____
History of HIV	_____	_____	_____	_____	_____	_____	_____
History of Herpes	_____	_____	_____	_____	_____	_____	_____
History of sexually transmitted disease	_____	_____	_____	_____	_____	_____	_____
Itching of genitals	_____	_____	_____	_____	_____	_____	_____
Burning or tingling on genitals	_____	_____	_____	_____	_____	_____	_____
Blisters or sores on genitals	_____	_____	_____	_____	_____	_____	_____
Hives	_____	_____	_____	_____	_____	_____	_____
Skin cancer	_____	_____	_____	_____	_____	_____	_____
Melanoma	_____	_____	_____	_____	_____	_____	_____
Cancer of another type	_____	_____	_____	_____	_____	_____	_____
Acne	_____	_____	_____	_____	_____	_____	_____
Pimples or Folliculitis	_____	_____	_____	_____	_____	_____	_____
Spider or Leg Veins	_____	_____	_____	_____	_____	_____	_____
Insect bites	_____	_____	_____	_____	_____	_____	_____
Cosmetic surgery	_____	_____	_____	_____	_____	_____	_____
Asthma or Hay Fever	_____	_____	_____	_____	_____	_____	_____
Eczema	_____	_____	_____	_____	_____	_____	_____
Psoriasis	_____	_____	_____	_____	_____	_____	_____
Nail / Hair problems	_____	_____	_____	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____	_____	_____	_____
Cold sores	_____	_____	_____	_____	_____	_____	_____
Phlebitis	_____	_____	_____	_____	_____	_____	_____
Bleeding tendency	_____	_____	_____	_____	_____	_____	_____
Congenital moles	_____	_____	_____	_____	_____	_____	_____
Color or pigment problems of skin	_____	_____	_____	_____	_____	_____	_____
Sensitivity to sunlight, or easy burning	_____	_____	_____	_____	_____	_____	_____
Excess hair growth anywhere	_____	_____	_____	_____	_____	_____	_____
Lupus Erythematosus	_____	_____	_____	_____	_____	_____	_____
Lyme disease	_____	_____	_____	_____	_____	_____	_____

Any other problems not listed? _____

How many packs of cigarettes do you smoke a day? _____

How many beers, or cocktails per day? _____ Specify: _____

List any hobbies (gardening, tropical fish, etc.) or favorite sports: _____



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Date: _____

Sex: M _____ F _____ Name: _____

Age: _____

HISTORY

Allergies:

Medications: Information history sheet reviewed _____

Other Information: _____

Hospitalization: Information history sheet reviewed _____

Other Information: _____

Complete Systems Review: Information history sheet reviewed _____

Other Information: _____

Chief Complaints:

Extended History of Present Illness:



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**PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

I hereby give my consent for Jeffrey Rapaport, M.D., P.A., William Boss, M.D., P.A., Jason Staback, PA-C., and the staff of the Cosmetic Skin & Surgery Center (heretofore referred to as the Cosmetic Skin & Surgery Center) to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I have been informed of my right to review the Notice of Privacy Practices prior to signing this consent for a more complete description of such uses and disclosures. I am aware that the Cosmetic Skin & Surgery Center reserves the right to revise its Notice of Privacy Practice at any time, and that in this event a revised Notice of Privacy Practices may be obtained by forwarding a written request to the office manager, Eva Baer.

With this consent, the Cosmetic Skin & Surgery Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care.

With this consent, the Cosmetic Skin & Surgery Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as our newsletter and billing statements.

With this consent, the Cosmetic Skin & Surgery Center may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as our newsletter.

I have the right to request that the Cosmetic Skin & Surgery Center restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the Cosmetic Skin & Surgery Center's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the Cosmetic Skin & Surgery Center may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print Name of Patient

Print Name of Legal Guardian

Date