DEPARTMENT OF DERMATOLOGY

Stony Brook Medicine

Dear Patient,

We welcome you to Stony Brook Dermatology Associates. It is important not to rush through these forms since important (requested) data such as your medical history must be accurate and thorough. If you are unsure of any section, leave it blank and we will assist you when you arrive.

Please remember to bring your completed forms, your insurance card so that we can scan it into your electronic medical record and your referral (if applicable). Insurance referrals authorize payment for medical services & if you are insured with a carrier that requires one, it is your responsibility to obtain it & confirm that it has either been submitted electronically by your primary care physician (PCP) and or received in the office. If you need the ID# for the dermatologist you will be seeing here, we are more than happy to provide you with the information you need to ease the process. **All (paper) referrals should be sent to fax# 631-638-4220.**

Once you have checked in with reception you will be seen by billing to verify your insurance eligibility and copayment responsibility. *We respectfully request a minimum 24hr. advance notice if you need to cancel or reschedule to avoid a "No Show" fee.* We understand that you may have changes to your own schedule however, our goal is to maximize appointment availability to ensure that all patients on our wait list can avail themselves of unexpected appointment openings.

If you have any questions prior to your visit, please feel free to contact us @ 631-444-4200 and we will be happy to assist you.

Sincerely,

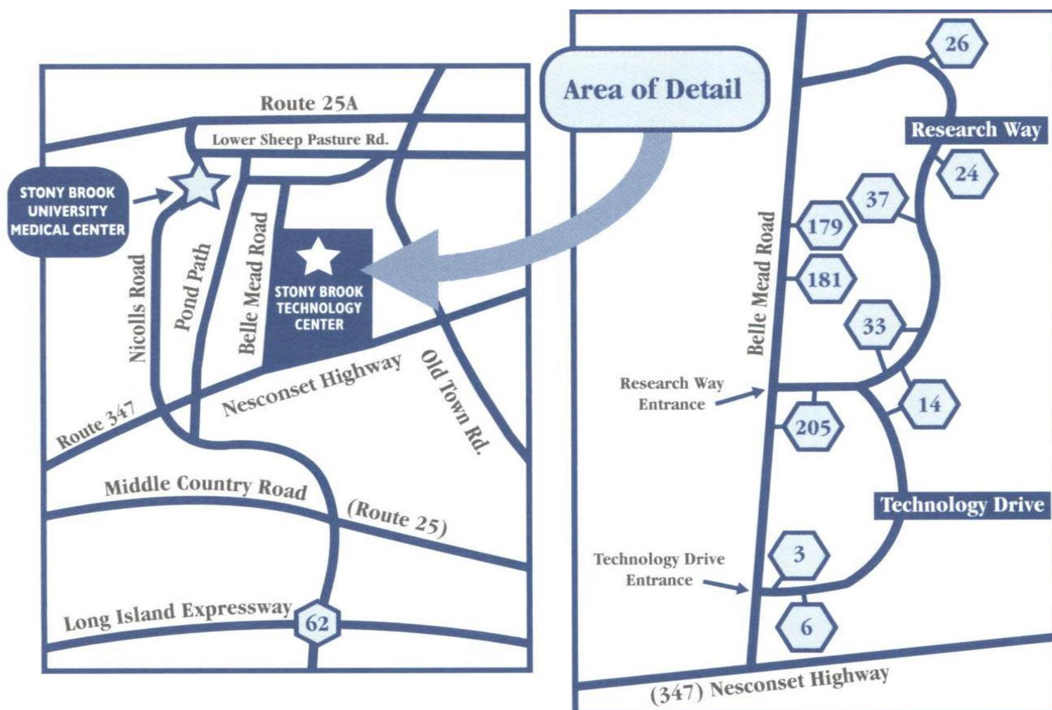
Julie Bouziotis
Practice Manager

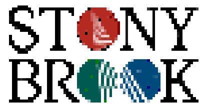
Stony Brook Dermatology Associates
181 Belle Mead Road Suite #5
East Setauket, New York 11733-9221
www.stonybrookphysicians.com
Phone: 631-444-4200 Nursing Fax: 631-444-4276 Reception Fax: 631-638-4220

a Map for your convenience

Directions to our office can be obtained by calling our main number @ 631-444-4200 and pressing option 4.

- **From the LIE (Long Island Expressway)** take exit 62 and follow signs for Route 97 N Nicolls Road. Continue on Nicolls Road to Route 347 (Nesconset Highway) and make a right. At the 3rd traffic light make a left onto Belle Mead Rd. You will be entering Technology Park. Continue on Belle Mead Rd. to #181 & turn right into the parking lot.
- **From the NS (Northern State Parkway)** please follow it to the end & follow signs for Route 347 (Nesconset Highway). Cross over Nicolls Road and make a left at the 3rd traffic light onto Belle Mead Rd. You will be entering Technology Park. Continue on Belle Mead Rd. to #181 & turn right into the parking lot.
- **From Route 347 (Nesconset Highway) traveling West** make a Right onto Belle Mead Rd. You will be entering Technology Park. Continue on Belle Mead Rd. to #181 & turn right into the parking lot.
- **From Route 347 (Nesconset Highway) traveling East** you will cross over Nicolls Rd. & make a left onto Belle Mead Rd. which is the 3rd traffic light. You will be entering Technology Park. Continue on Belle Mead Rd. to #181 & turn right into the parking lot.
- **From 25A traveling East** make a Right onto Nicolls Rd. traveling South and continue to Route 347 (Nesconset Highway) and make a Left. At the 3rd traffic light make a Left onto Belle Mead Rd. You will be entering Technology Park. Continue on Belle Mead Rd. to #181 & turn right into the parking lot.
- **From 25A traveling West** make a Left onto Nicolls Rd. traveling South and continue to Route 347 (Nesconset Highway) and make a Left. At the 3rd traffic light make a Left onto Belle Mead Rd. You will be entering Technology Park. Continue on Belle Mead Rd. to #181 & turn right into the parking lot.





State University of New York
UNIVERSITY HOSPITAL
AND MEDICAL CENTER
Stony Brook, New York 11794

AMBULATORY CARE SUMMARY LIST

Service: ___________________________________

Service Phone # ______________________________

Pt. Name: ___________________________________

M.R.#: ___________________________________

D.O.B.: ___________________________________

Phone (h)___________________________________

(c)___________________________________

(w)___________________________________

Ambulatory Care Guide Given ☐ (date) ____________

Advanced Directive Documents Received from Patient ☐ (date) _________

Allergies / Adverse Reactions (Describe) ☐ No Known Allergies

Allergy	Description	Allergy	Description	Allergy	Description

Diagnoses/ Medical Conditions

DATE		DATE RESOLVED	DATE		DATE RESOLVED

Heart valve problems such as MVP? Yes No
Artificial joints? Yes No
Hepatitis? Yes No
Pacemaker/Defibrillator? Yes No

Do you need antibiotic prophylaxis? Yes No
If yes, please list___________________________________

Past Operative/Invasive Procedures

Past Operative/Invasive Procedure	Date	Past Operative/Invasive Procedure	Date

Medications (prescribed for or used by the patient)

Start Date	Medication Name	Dose	Route	Frequency	Stop Date

Stony Brook Medicine

Stony Brook Dermatology Associates Registration Form

Name: ____

Last **First** **MI** **Suffix**

☐**Mr.** ☐**Mrs.** ☐**Ms.** ☐**Miss** ☐**Dr**

Address: ____

Street # **Street Name** **Apt#**

____

City **State** **Zip**

Home Phone: ________-________-________ Cell phone#________-________-________ Email address: ______________________

Social Security # _________-_________-_________ **Employer: ________________________________**

Primary Insurance: ___________________________**ID#** ___________________________ **Referral Required? Y N**

FAMILY HISTORY: Please indicate if there is a family history of any skin conditions or cancers Y N

Relationship to you – Father/Mother/Sister/Brother/Other__________________________

MEDICAL HISTORY: Please circle yes or no if you **have** or **have had** any of the following:

Y N HEART DISEASE
Y N HIGH BLOOD PRESSURE
Y N BREATHING PROBLEMS
Y N DIABETES
Y N THYROID DISEASE
Y N PROSTATE DISORDER
Y N LIVER DISORDER
Y N STOMACH/INTESTINAL DISORDER
Y N EAR OR EYE DISORDER
Y N JOINT PAIN
Y N HIV/AIDS

Y N STROKE
Y N CANCER
Y N SKIN CANCER
Y N ANY SKIN DISEASE
Y N PSYCHIATRIC CONDITION
Y N SEIZURES
Y N WEIGHT LOSS
Y N BLEEDING DISORDER
Y N MIGRAINES
Y N Other ______________________

Please indicate:
Height: ____'____" Weight: ______ lbs.

SOCIAL HISTORY:

1. Do you use Tobacco Y N If yes, how much_______________
2. Do you use Alcohol Y N Social Weekends Daily (please circle)
3. Occupation ____________________ 4. SINGLE MARRIED DIVORCED WIDOWED (please circle)

Females only:
5. Are you pregnant? Y N **6.** Are you planning to become pregnant? Y N

7. Are you breast-feeding? Y N

Primary/Family Physician Name & Address

____

____

Phone #____________________________________

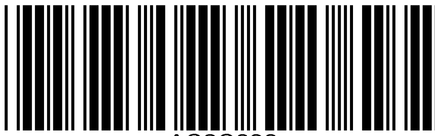
Referring Physician Name & Address

____

____

Phone #_____________________________

____ DATE ________/________/________
PATIENT (OR GUARDIANS) SIGNATURE



STONY BROOK UNIVERSITY MEDICAL CENTER

ADULT PATIENT NEEDS ASSESSMENT

Communication:

Do any of the following apply to you?

☐ Impaired Vision
☐ Impaired Hearing
☐ Reading or Speaking Problems
☐ Pain
☐ Concerns about your illness
☐ None of the above
☐ Other ______________________________

What is your primary language? _________________________

Do you have difficulty understanding English? ☐ Yes ☐ No

Can you read English? ☐ Yes ☐ No

What language do you prefer when receiving information? ______________________

Culture:

Do you have any Cultural/ Religious/ Spiritual Practices that are important for us to know to provide your health care?

☐ Yes ☐ No If Yes, please describe____

____

Learning Preference:

How do you prefer to learn?

☐ Reading ☐ Person explaining to me ☐ Seeing/pictures ☐ Demonstration ☐ Video/Television

Is there anyone you would like to have with you during your teaching? If so, whom? __________________

Domestic Concerns:

Have you been a victim of mental or physical abuse? ☐ Yes ☐ No

Do you feel that you are currently in danger at home? ☐ Yes ☐ No

Falls Risk:

Do you have a fear of falling? ☐ Yes ☐ No

Have you fallen in the last 12 months? ☐ Yes ☐ No

If you answered “YES” to either of these two questions, please notify staff immediately.

Nutrition Screen:

Have you noticed a decrease in appetite within the last month? ☐ Yes ☐ No

Have you had an unexplained weight loss (over 10 lb.) over the past 3-6 months? ☐ Yes ☐ No

Please describe your appetite: ☐ Good ☐ Fair ☐ Poor ☐ Other _________________________

Patient/Designee Signature: ___________________________________Date: _____________

Practitioner Signature:_______________________ ID#:___________ Date: ______Time: _______

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):	Pharmacy Name (2nd Choice):
___________________________________	___________________________________
Street Name, Town OR ZIP CODE:	Street Name, Town OR ZIP CODE:
___________________________________	___________________________________
Ph#: ________-_________-__________ (if known)	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
181 BELLE MEAD ROAD
SUITE 5
SETAUKET, NY 11733

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: _______________________________

Ambulatory Care Consent Form

Patient Name: ______________________________ Date of Birth: ______________

MRN: __________________ Enc#: _____________________

By signing below I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the Hospital and its staff.

____
Signature of Patient or Patient Representative

____
Print Name of Patient or Personal Representative

____
Relationship, if signed by person other than Patient

____
Date

____
Description of Personal Representative's Authority

NEW PATIENT PAPERWORK PACKAGE "CHEAT SHEET"

Page 1: "**AMBULATORY CARE SUMMARY LIST**"

This is to be complete by the patient or patient's guardian. This provides your doctor with medical history & clinical information that becomes part of your medical record (4 separate & distinct categories)

Allergies/Medical Conditions/Past Procedures/Medications

In any section where there is no applicable information for you to enter, please write in "N/A" to indicate that this is not applicable

Remember that it's important to provide any & all information within each category that is known to you

Page 2: **Related Historical Information Sheet/Primary Care Physician & HIPAA information**

PLEASE write your name on top

- These are a series of Yes & No questions – please answer ALL
- Please complete current PCP & Referring physician information
- Don't forget to answer the permission to discuss your medical condition (HIPAA) question @ the bottom
- Do NOT forget to sign @ the bottom!

Page 3: "**Adult Patient Needs Assessment**"

It is critical that this be completed in its entirety to ensure that we plan proper accommodations if needed. **IF** the patient is a ***child***, the following sections apply to his/her guardian:

- Communication
- Culture
- Learning Preference
- Domestic Concerns

  Falls Risk & **Nutrition Screen** applies to the child/patient

Page 4: "**E-Prescribing Consent Form**"

- Please only list known DRUG allergies. If none know indicate N/A
- Enough pharmacy information for us to locate & identify correctly on google search
- Sign & Date

Page 5: "**Communication Consent" – Patient HIPAA Approval**

Page 6: "**Ambulatory Care Consent Form**"

This form is requesting your consent to receive care in our outpatient facility

- Please write in your name & D/O/B
- Sign on the 1st signature line IF you are the patient or patient representative
- Indicate your relationship IF you are NOT the patient who has signed
- Please write in the date

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