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,

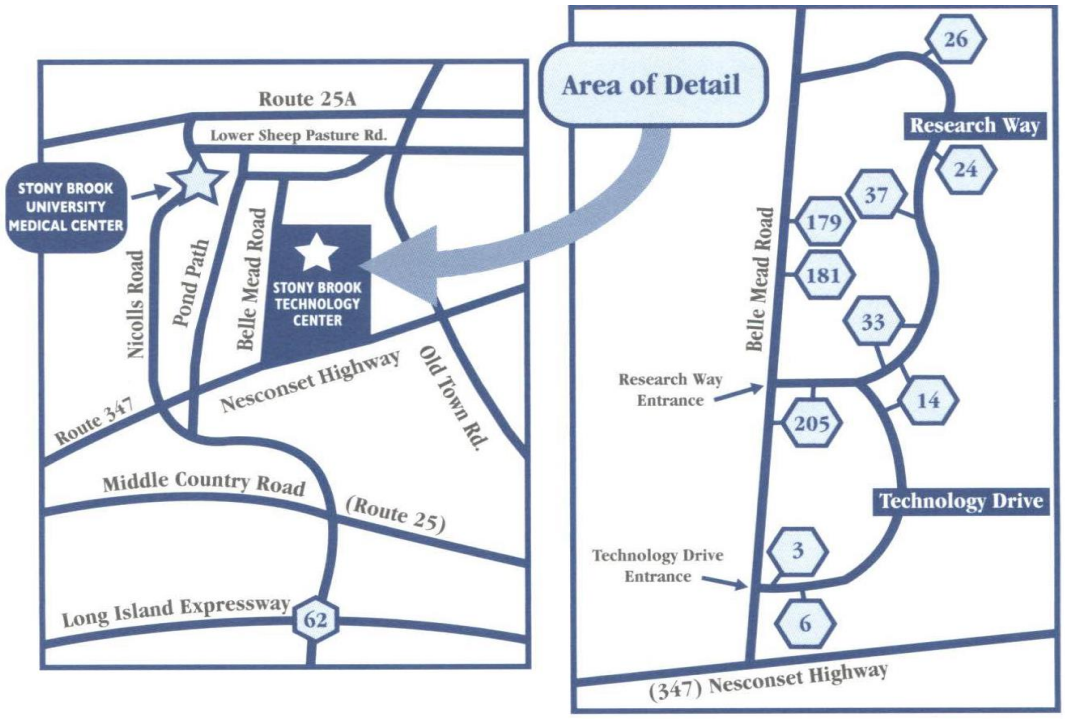
Julie Bouziotis
Practice Manage

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.



STONY BROOK

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 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	STROKE
Y N	HIGH BLOOD PRESSURE	Y N	CANCER
Y N	BREATHING PROBLEMS	Y N	SKIN CANCER
Y N	DIABETES	Y N	ANY SKIN DISEASE
Y N	THYROID DISEASE	Y N	PSYCHIATRIC CONDITION
Y N	PROSTATE DISORDER	Y N	SEIZURES
Y N	LIVER DISORDER	Y N	WEIGHT LOSS
Y N	STOMACH/INTESTINAL DISORDER	Y N	BLEEDING DISORDER
Y N	EAR OR EYE DISORDER	Y N	MIGRAINES
Y N	JOINT PAIN	Y N	Other _____
Y N	HIV/AIDS	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

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: _____

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):

_____

Street Name, Town OR **ZIP CODE**:

_____

Ph#: _____-_____-_____ (if known)

Pharmacy Name (2nd Choice):

_____

Street Name, Town OR **ZIP CODE**:

_____

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

Stony Brook Medicine
STONY BROOK
Stony Brook Southampton Hospital
Stony Brook Children's

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