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
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 Route 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 Route 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.
Ambulatory Care Summary List

Pt. Name: ______________________________
M.R.#: ________________________________
D.O.B.: ______________________________
Phone (h) ______________________________
      (c) ________________________________
      (w) ________________________________

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

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<tr>
<th>Allergy</th>
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Diagnoses / Medical Conditions

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<th>DATE</th>
<th>DATE RESOLVED</th>
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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

<table>
<thead>
<tr>
<th>Past Operative / Invasive Procedure</th>
<th>Date</th>
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Medications (prescribed for or used by the patient)

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<tr>
<th>Start Date</th>
<th>Medication Name</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
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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               Referring Physician Name & Address
__________________________________________

__________________________________________

Phone #______________ Phone #______________

__________________________________________  DATE _______/______/_______

PATIENT (OR GUARDIANS) SIGNATURE
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):

__________________________________________

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 ____________
COMMUNICATION CONSENT

STONEY 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