CINDY HOFFMAN, D.O., PC; DERMATOLOGY
INITIAL VISIT QUESTIONAIRE

Name_____ **Reason for today's visit**_____
Today's date_____ _____

Are you allergic to any medications?
_____
_____
_____
_____

Are you currently taking any medications? (prescription, over the counter, vitamins) list
_____
_____
_____

Have you ever been treated for any of the following diagnoses or diseases:

Heart disease or pacemaker	yes	no	lung (ie. TB)	yes	no
High blood pressure	yes	no	stomach/intestinal	yes	no
Diabetes	yes	no	kidney/bladder	yes	no
Blood disorder	yes	no	liver/gall bladder	yes	no
Arthritis	yes	no	stroke/neurologic	yes	no
Emotional/psychiatric	yes	no	phlebitis	yes	no
Cancer	yes	no	eye disease	yes	no

Have you or anyone in your family had: **family member**

Asthma	yes	no	_____
Hay fever	yes	no	_____
Hives	yes	no	_____
Eczema	yes	no	_____
Psoriasis	yes	no	_____
Skin cancer	yes	no	_____
Melanoma	yes	no	_____
Other skin diseases	yes	no	_____

Have you ever had:

Difficulty with the healing of a wound	yes	no
Excessive bleeding when cut	yes	no
Overgrown scars or keloids	yes	no
Allergic reactions to local anesthetics	yes	no
Exposure to HIV (AIDS)	yes	no
Venereal Diseases	yes	no

Do you smoke	always	sometimes	never
Do you use a sunscreen	always	sometimes	never
When exposed to the sun do you	tan	tan and burn	burn

What soap do you use?_____**What moisturizer do you use?**_____

For Women Only

Are you pregnant or planning a pregnancy	yes	no
Do you take birth control pills	yes	no

PLEASE INFORM THE DOCTOR AT ANY TIME IF YOU PLAN TO OR BECOME PREGNANT DURING YOUR TREATMENT.

Cindy Hoffman, D.O., PC; 686 Stoneleigh Ave, Carmel, NY 10512

PATIENT INFORMATION (Please Print) Today's Date___/___/___

Name_____
Last *First* *MI*
Social Security #_____Date of Birth____/____/____Age_____Sex_____

Address_____
City *State* *zip*
Home Phone_____Work Phone_____Cell Phone_____

SPOUSE/PARENT INFORMATION EMAIL ADDRESS_____

Name of spouse/parent_____Address_____
Social Security # spouse/parent_____
Home Phone_____Work Phone_____Cell Phone_____

INSURANCE INFORMATION (Please present insurance card at time of check in)

Primary Insurance Name_____
Ins. Address_____
Name of Insured_____
Insured's ID#_____
Group #_____
Relationship of patient to insured_____
Employer Name_____
Employer Address_____
Employer Phone_____

Secondary Insurance Name_____
Ins. Address_____
Name of Insured_____
Insured's ID#_____
Group #_____
Relationship of patient to insured_____
Employer Name_____
Employer Address_____
Employer Phone_____

Other family members that are patients_____
Pharmacy of Choice_____Phone_____

Referred by:_____
Primary Care Physician:_____

PLEASE READ AND SIGN

I authorize treatment of my (my dependents) medical condition by Cindy Hoffman, DO, PC
I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. This assignment will remain in effect until revoked by me in writing.

Also, payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable copayments and deductibles will be collected, as well as any amount not covered by insurance. I also understand that I will be **responsible for my bill** for services rendered to me/my child **if a referral is not obtained from my primary care physician**, and it's required by my insurance carrier.

Dr. Hoffman does not participate with ALL insurance plans. If Dr. Hoffman does not accept my insurance, or if I have no insurance coverage, I understand that I am expected to pay in full when professional services are rendered. In the event that your account must be turned over to collections, a $20.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

I give permission to Dr Hoffman or her staff to take pictures of myself for medical or educational purposes.

Do we have permission to discuss your medical condition with a family member? Whom?_____
I have reviewed and received a copy of Dr. Hoffman's Notice of Privacy Practices.

Patient Signature_____Date_____