Dermatology & Skin Surgery Center, PA
David Adam Kiken, MD, FAAD

Diplomate of the American Board of Dermatology

Today's Date: ___________________________

PATIENT INFORMATION

Last Name: ____ First Name: __________________________

Date of Birth: ____________________________ Gender: M ____ F____

Marital: S___M___W____D____

Address: ____

____

Home Phone: ______________________________ Cell Phone: ___________________________________

Work Phone: ______________________________ Email: ____

Social Security #: ___________________________

Employer Name and Address: ____

Emergency Contact:

Name: ______________________________________ Phone(s): _________________________________

Address: ____

Primary Care Physician/Referring doctor (name & phone #): ___________________________________

Other referral source (friend, ad, website, etc.): ____

CURRENT SKIN PROBLEMS: Please explain the reason(s) for today's visit (skin concerns, check-up, cosmetic, etc.)

1. ____
   Site: __________________________How long has it been going on? _______________________
   Severity: _____________________________ Past treatment? ______________________________
2. ____
   Site: ___________________________ How long has it been going on? _____________________
   Severity: _____________________________ Past treatment? ______________________________
3. ____
   Site: __________________________ How long has it been going on? ______________________
   Severity: _____________________________ Past treatment? ______________________________

MEDICATIONS AND MEDICATION ALLERGIES

List all of the oral and/or topical medications that you use, including vitamins, herbal supplements, over-the-counter medications.

____
____

Allergies to medications (pills, injectable drugs, creams and lotions, etc.) ________________________________

____

Your Primary Pharmacy:

Name: ______________________________ Town: _____________________ Phone: ________________________

Social Habits:

Alcohol Use: Yes ____ No ____ How much? _____________ Quit? When __________________

Street Drugs: Yes ____ No _____ How much? _____________ Quit? When __________________

Smoking: Yes _____ No_______ How much? _____________ Quit? When__________________

PERSONAL SKIN HISTORY:

Please check Yes or No if you have or have had any of the following conditions:

Actinic Keratosis ("precancer") Yes ___ No___

Acne: Yes___ No___

Excessive hair growth: Yes___ No___

Excessive Sweating: Yes___ No____

Eczema or Atopic Dermatitis: Yes___ No___

Lupus, erythematosus: Yes ___No___

Psoriasis: Yes ___ No____

Pigmentary Problems: Yes___ No____

Rosacea: Yes___ No___

Keloid Scarring; Yes___ No___

Have you ever had skin cancer? Yes ___ No ____ If so, in what year__________ Site _____________________

Please indicate type: Basal cell ____ Squamous Cell ____ Melanoma ____ Other ____

Have you ever had any other skin conditions? ____

GENERAL MEDICAL HISTORY: Please list all previous or current medical problems, illnesses and major diagnoses, along with the dates thereof: ____

____
____
____

For Women: Are you pregnant? Yes_____ No _____ If you are nursing, are you breast feeding? Yes ___ No ____

Are you using Birth Control? Yes ___ No ___ If so, please indicate method: ________________________________

SURGICAL HISTORY: Please list all previous surgeries and other medical procedures you have undergone, along with the dates thereof: ____

____
____
____

FAMILY HISTORY Please check Yes or No if you have a family history of any of the following conditions:

Acne: Yes ___ No ___

Basal Cell Carcinoma: Yes ___ No ___

Squamous Cell Carcinoma: Yes ___ No ___

Melanoma: Yes ___ No ___

Eczema: Yes ___ No ___

Rheumatoid Arthritis: Yes ___ No ____

Lupus, erythematosus: Yes ___ No ___

Psoriasis: Yes ___ No ___

Pigmentary Problems: Yes ____ No ___

Rosacea: Yes ___ No ___

Other family medical history (skin conditions and/or other conditions): ___________________________

____
____

SYMPTOM REVIEW

Are you currently having problems in any of the areas below? If so, circle each area in which you have a problem.

Allergies	Fevers, chills, sweats	Male reproductive organs
Bleeding	Thyroid / other endocrine	Joints / Back / Neck
Breathing	Eyes	Neurological
Heart	Stomach	Mood / Psychiatric
Weight loss or gain	Female reproductive organs	Ears / Nose / Throat

REVIEW OF SYSTEMS

Do you have trouble with wound healing? Yes ___ No ___

Do you tend to bleed excessively? Yes ___ No ___

Do you have a tendency to form hypertrophic scars and keloids? Yes ___ No ___

Have you had allergic reactions to bandages and tape? Yes ___ No ___

Do you have enlarged lymph nodes? Yes ___ No ___

Are you immunosuppressed? (HIV/AIDS or a history of lymphoma or leukemia) Yes __ No __

Do you have a prosthetic hip or knee joint? Yes ___ No ___

Do you have a pacemaker or defibrillator? Yes ___ No ___

Do you take aspirin or coumadin or other anticoagulants? Yes ___ No ___

Do you have mitral valve prolapse? Yes ___ No ___

Do you have a history of blood clots or emboli? Yes ___ No ___

Have you ever fainted or become light-headed during minor surgical procedures? Yes ___ No ___

Would you like information on (please circle):

- Botox treatments
- Dermal Fillers (Radiesse, Juvederm, Restylane, Belotero)
- Scar treatments (e.g. acne scars)
- Spider and varicose vein treatment

Patient Signature: ____ Date: ____________________

SIGNATURE-ON-FILE AND FINANCIAL AGREEMENT

I, ____, acknowledge that Dermatology & Skin Surgery Center, PA, will bill the insurance company about which I have provided information on the day of my visit, as a courtesy to me. However, as the patient, it is my responsibility to accept and understand the complete details of my individual insurance plan. It is my responsibility to obtain a referral, if necessary. In addition, I am ultimately responsible for my medical bills including copayments at the time of service, as well as any services that are applied to a deductible or coinsurance under the terms of my insurance policy., I am responsible for payment, for whatever reason, I become ineligible with this insurance company at the time of service, if my insurance company denies payment for any reason for a service, as well as any services that are applied to a deductible or coinsurance.

Patient Signature: ____ Date: _____________________

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I WAS PROVIDED OR OFFERED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND THAT I READ (OR HAD THE OPPORTUNITY TO READ IF I SO CHOOSE) AND UNDERSTAND THE NOTICE.

______________________________	______________________________
Print Name	Date
______________________________	______________________________
Parent or Authorized Representative	Date
______________________________	______________________________
Signature	Date

Note

This acknowledgement shall remain valid for a period of six (6) years from date of signing.

If you would like to review, read, or take a copy of the notice of privacy practices, please ask a member of Dr. Kiken's staff.

Dermatology and Skin Surgery Center

David A. Kiken, M.D, F.A.A.D

205 Ridgedale Avenue
Florham Park, NJ 07932
973-301-9500

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

PATIENTS PLEASE NOTE: The practice is not required to agree to your request. Please see our notice of privacy practices for more information regarding such requests.

Patient Name:____ ____DOB: ___________________________

Patient Address: ____

City: ____ State: _____________________ Zip: __________________

Please mark where you **DO NOT** want us to contact you:

(If no restrictions, please check "**NO RESTRICTIONS**" and sign below)

- Home phone
- Home address
- Work phone
- Work address
- Spouse's work
- Email
- Other ________________
- **NO RESTRICTIONS** ______

Please mark any information that may not be shared with you other physicians, pharmacy, or your insurance company:

- Occupation
- Name of employer
- Visit notes/hospital notes
- Prescription information
- Patient history
- Other ________________
- **NO RESTRICTIONS** ______

*** **PAYMENT AND/OR CLAIMS MAY BE DENIED IF CERTAIN INFORMATION IS RESTRICTED FROM YOUR INSURANCE COMPANY** ***

Signature of Patient or Legal Guardian: ________________________________ Date: ______________

Dermatology and Skin Surgery Center

Credit Card Authorization Form

I authorize Dermatology and Skin Surgery Center to charge outstanding balances on my account to the following credit card:

Please circle one:

Visa	**Mastercard**	**Discover**

Card Number: ____

CCV: ____________________________________ Expiration Date: ______________________________

Name on card (please print): ____

Signature: ____ Date: _____________________

Background for Credit Card Authorization: **PLEASE READ**

As you know if you have ever checked into a hotel, or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

We have implemented a similar policy. You will be asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share. Your card **WILL NOT** be automatically charged. However, after 2 (two) statements and if we have not received payment then the credit card on file will be charged for the remaining balance.

In healthcare, the reason for this is that many private insurance companies have initiated co-insurance and deductibles that are the patient's responsibility. This will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combinations will benefit everyone in helping to keep the cost of health care down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

If you have any questions about this payment method, do not hesitate to ask.

Any added written addendums are not binding.