SP

SUTTON PLACE
DERMATOLOGY

PATIENT INFORMATION

ACCOUNT NUMBER: _____ (OFFICE USE ONLY) REFERRING PHYSICIAN: _____ (OFFICE USE ONLY)

NAME: _____ MARITAL STATUS (OPTIONAL): _____

HAVE YOU HAD A COVID-19 VACCINE? _____ IF YES, WHICH ONE?: _____

DATE OF FIRST DOSE: _____ DATE OF SECOND DOSE: _____

STREET ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____

HOME / CELL PHONE: _____ BUSINESS / CELL PHONE: _____

DATE OF BIRTH: _____ SEX: ☐ MALE ☐ FEMALE

SOCIAL SECURITY NUMBER: _____ OCCUPATION: _____

NAME OF EMPLOYER / SCHOOL: _____

STREET ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____

MUST PROVIDE EMERGENCY CONTACT

NAME: _____ PHONE: _____

STREET ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____

"I VERIFY THE ACCURACY OF THE ABOVE INFORMATION AND I AUTHORIZE THE RELEASE OF INFORMATION AS PROVIDED IN THE PRIVACY POLICIES I HAVE READ".

PATIENT (OR AUTHORIZED SIGNATURE): _____ DATE: _____

"I AM IN AGREEMENT TO PAY STATEMENT IN THE EVENT OF INSURANCE DENIAL."

PATIENT (OR AUTHORIZED SIGNATURE): _____ DATE: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, HAVE RECEIVED A COPY OF SUTTON PLACE DERMATOLOGY'S NOTICE OF PRIVACY PRACTICES.

SIGNATURE OF PATIENT: _____ DATE: _____

HISTORY AND INTAKE FORM

PAST MEDICAL HISTORY: (PLEASE CHECK ALL THAT APPLY)

- ☐ ANXIETY
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ ATRIAL FIBRILLATION
- ☐ BONE MARROW TRANSPLANTATION
- ☐ BREAST CANCER
- ☐ COLON CANCER
- ☐ COPD
- ☐ CORONARY ARTERY DISEASE
- ☐ HIGH CHOLESTEROL
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ END STAGE RENAL DISEASE
- ☐ GERD
- ☐ HEARING LOSS
- ☐ HEPATITIS
- ☐ HIGH BLOOD PRESSURE
- ☐ HIV/AIDS
- ☐ THYROID PROBLEMS
- ☐ LEUKEMIA
- ☐ LUNG CANCER
- ☐ LYMPHOMA
- ☐ PROSTATE CANCER
- ☐ RADIATION TREATMENT
- ☐ SEIZURES
- ☐ STROKE
- ☐ NONE

OTHER: _____

PAST SURGICAL HISTORY: (PLEASE CHECK ALL THAT APPLY)

- ☐ APPENDIX REMOVED
- ☐ BLADDER REMOVED
- ☐ MASTECTOMY (RIGHT, LEFT, BILATERAL)
- ☐ LUMPECTOMY (RIGHT. LEFT, BILATERAL)
- ☐ BREAST BIOPSY (RIGHT, LEFT, BILATERAL)
- ☐ BREAST REDUCTION
- ☐ BREAST IMPLANTS
- ☐ COLECTOMY: COLON CANCER RESECTION
- ☐ COLECTOMY: DIVERTICULITIS
- ☐ COLECTOMY: IBD
- ☐ GALLBLADDER REMOVED
- ☐ CORONARY ARTERY BYPASS
- ☐ MECHANICAL VALVE REPLACEMENT
- ☐ BIOLOGICAL VALVE REPLACEMENT
- ☐ HEART TRANSPLANT
- ☐ JOINT REPLACEMENT, KNEE (RIGHT, LEFT, BILATERAL)
- ☐ JOINT REPLACEMENT, HIP (RIGHT, LEFT, BILATERAL)
- ☐ JOINT REPLACEMENT WITHIN LAST 2 YEARS
- ☐ KIDNEY BIOPSY (NEPHRECTOMY)
- ☐ KIDNEY REMOVED (RIGHT, LEFT)
- ☐ KIDNEY STONE REMOVAL
- ☐ KIDNEY TRANSPLANT
- ☐ OVARIES REMOVED: ENDOMETRIOSIS
- ☐ OVARIES REMOVED: CYST
- ☐ OVARIES REMOVED: OVARIAN CANCER
- ☐ PROSTATE REMOVED: PROSTATE CANCER
- ☐ PROSTATE BIOPSY
- ☐ TURP (PROSTATE REMOVAL)
- ☐ SPLEEN REMOVED
- ☐ TESTICLES REMOVED (RIGHT, LEFT BILATERAL)
- ☐ HYSTERECTOMY: FIBROIDS
- ☐ HYSTERECTOMY: UTERINE CANCER
- ☐ NONE

OTHER: _____

SKIN DISEASE HISTORY: (PLEASE CHECK ALL THAT APPLY)

- ☐ ACNE
- ☐ ACTINIC KERATOSES
- ☐ ASTHMA
- ☐ BASAL CELL SKIN CANCER
- ☐ BLISTERING SUNBURNS
- ☐ DRY SKIN
- ☐ ECZEMA
- ☐ FLAKING OR ITCHY SCALP
- ☐ HAY FEVER / ALLERGIES
- ☐ MELANOMA
- ☐ POISON IVY
- ☐ PRECANCEROUS MOLES
- ☐ PSORIASIS
- ☐ SQUAMOUS CELL
- ☐ SKIN CANCER
- ☐ NONE

OTHER: _____

DO YOU WEAR SUNSCREEN? ☐ YES ☐ NO

IF YES, WHAT SPF?: _____

DO YOU TAN IN A TANNING SALON? ☐ YES ☐ NO

DO YOU HAVE A FAMILY HISTORY OF MELANOMA? ☐ YES ☐ NO

IF YES, WHICH RELATIVE(S)? _____

MEDICATIONS: (PLEASE ENTER ALL CURRENT MEDICATIONS) _____

_____

_____

ALLERGIES: (PLEASE ENTER ALL ALLERGIES) _____

_____

_____

SOCIAL HISTORY: (PLEASE ENTER ALL SOCIAL HISTORY) _____

_____

_____

SOCIAL HISTORY: (PLEASE CHECK ALL THAT APPLY)

CIGARETTE SMOKING:

- ☐ CURRENTLY SMOKES
- ☐ HAS SMOKED IN THE PAST
- ☐ NEVER SMOKED
- ☐ FORMER SMOKER

ALCOHOL USE:

- ☐ ETOH - NONE
- ☐ ETOH - LESS THAN 1 DRINK PER DAY
- ☐ ETOH - 1 - 2 DRINKS PER DAY
- ☐ ETOH - 3 OR MORE DRINKS PER DAY

OTHER: _____

FAMILY HISTORY (ONLY FIRST DEGREE RELATIVES)

_____

_____

_____

_____

PREFERRED LANGUAGE: _____

RACE: _____ ETHNIC GROUP: _____

PREFERRED PHARMACY NAME: _____

PHONE: _____

CITY OR ZIP CODE: _____

PLEASE ALLOW 24 HOURS FOR ANY APPOINTMENT CANCELLATIONS OR THERE WILL BE A NON-CANCELLATION FEE OF $50.

SP

SUTTON PLACE
DERMATOLOGY

PLEASE LET US KNOW IF YOU ARE INTERESTED IN INFORMATION ON ANY OF THESE PROCEDURES

CIRCLE BELOW:

WRINKLE TREATMENTS	RESTYLANE, SCULPTRA, RADIESSE, JUVEDERM, VOLUMA
FROWN LINES/CROWSFEET	BOTOX, XEOMIN, DYSPORT
SCAR/SPOT TREATMENTS	FRAXEL, IPL
UNWANTED FAT	COOLSCULPTING
CELLULITE ELIMINATION	CELLFINA
DOUBLE CHIN	KYBELLA
HAIR REMOVAL	ND-YAG
HAIRLOSS TREATMENT	PRP, PROPECIA
NON-INVASIVE FACELIFT	ULTHERA
SPIDER VEINS/FACIAL VEINS	SCLEROTHERAPY, LASER
SUN DAMAGE	PHOTODYNAMIC TREATMENT