General Intake Form

Last Name: _____ First Name: _____ M.I. _____

Date of Birth: ___/___/_____ Age: _____ Sex: M F Social Security #: _____

Address: _____

Street House/Apt # City State Zip _

Race: White African American Asian/Pacific Islander Hispanic Other (specify) _____

Preferred Language: English Spanish Other (specify) _____

Marital Status: Single Married Divorced Widowed Other

Home Phone #: _____ Cell Phone #: _____ Office Phone #: _____

Email: _____

Okay to leave message about health information at (circle any that apply): Home Mobile Office Email

How would you like your future appointment to be confirmed? Call Text *Carrier*_____

Parent's Information (if patient is under 18 years of age)

Last Name: _____ First Name: _____ Date of Birth: ___/___/_____

Address: _____

Street House/Apt # City State Zip

Home Phone: _____ Cell Phone: _____ Email: _____

Insurance Information

Company Name: _____ Policy/Member ID: _____

Policy Holder: _____ Relationship to Patient: Self Spouse Parent Other

Policy Holder's Date of Birth: ___/___/_____ SS#: _____ Sex: M F

Referred By ____ Doctor (Name_____) ____ Family/Friend ____ ZocDoc____ Insurance
____ Internet ___Referral Service ____ Other, please specify_____

Primary Care Physician: _____ Phone: _____

****Preferred Pharmacy:*** _____ Phone: _____

Address & **ZIP CODE**: _____

Emergency Contact Name:_____ Relationship: _____

Phone Number: _____

Acknowledgement of HIPAA notice of privacy practices

I hereby acknowledge that I have fully reviewed and/or have received a complete copy of the HIPAA notice of private practices provided by the staff of this office.

Medicare/Medicaid Assignment of Benefits

I certify that the information given by me in applying for payment is correct. I authorize release of all records upon request. I request that payment of authorized benefits be made on my behalf.

Assignment of Insurance Benefit

I hereby authorize direct payment of medical benefits to Pura Dermatology, LLC/Saurabh Lodha, MD for services rendered by all medical providers in the corporation. I understand that I am financially responsible for any balance if my insurance is invalid and I am responsible for copays, remaining balances, deductibles/co-insurance payments, as well as any cosmetic procedures not covered by insurance.

_____ _____ _____

Signature Relationship Date

Medical Intake Form

Patient Name: _____ Age_____ DOB_____ Height_____ Weight _____

Primary Care Physician _____ Allergies: _____ Latex __ Y __ N

Reason for Visit: _____

Medical Problems or Conditions: _____

	Yes	No	Details
Have you ever had skin cancer?			
Have you ever had melanoma?			
History of any skin disorders?			
History of tanning bed use?			
History of blistering sun burns?			
Anyone in the family with any skin cancer or melanoma?			
Anyone in the family with any skin problems?			

(Women): Are you pregnant? Yes __ No ___ Planning to become pregnant? Yes __ No ___

Current Medications (including supplements, herbs, vitamins): _____

_____

Surgical Procedures you have had: _____
Heart valve replacement ___ Yes (Year _____) ___ No **Knee Replacement** ___ Yes (Year _____) ___ No

Do you smoke? ___ Yes ___ No If YES, how many cigarettes per day? _____

Do you drink alcohol? ___ Yes ___ No If YES, how many drinks per day? _____

Do you, or have you used IV drugs? ___ Yes ___ No What is your occupation? _____

Review of Systems: Current or past problems with:

	Yes	No		Yes	No
General Health			Thyroid		
Allergic Reactions			Lungs		
Blood/Bleeding Disorder			Diabetes		
Liver			Eyes		
Psychological Disorder			**Pacemaker**		
Heart			Kidneys		
Fainting with Medical Procedures			Skin		
Asthma			Ears/Nose		
Seizures			Throat/Mouth		
Artificial Joints			Stomach/Bowel		
Heart Valves			Joints		
Dialysis			Muscles		

Reviewed by: _____ Date: _____

Pura DERMATOLOGY
Medical, Aesthetic and Pediatric Dermatology

446 West 38th Street New York, NY 10018
Tel: (646)706-7747
Fax: (646)706-7732

24 HOUR CANCELLATION POLICY

I _____ understand and agree to the following:

Regular Appointments:
I understand that it is my responsibility to notify Pura Dermatology 24 hours in advance if I am unable to keep my scheduled appointment with Dr. Lodha or our Clinical Aesthetician, Debbie Arteaga. I am also aware that I will be billed the contracted rate of $50.00 in the event that I fail to change or reschedule my appointment 24 hours in advance.

Procedure Appointments:
I understand that it is my responsibility to notify Pura Dermatology 24 hours in advance if I am unable to keep my scheduled appointment, in which I am having a procedure performed. I am also aware that I will be billed the contracted rate of $250.00 in the event when I am more than 15 min late to my appointment or fail to change or reschedule my appointment 24 hours in advance. *There is no fee if the appointment is cancelled or rescheduled 24 hours in advance.

_____ _____

Signature of Patient/Parent Date

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At Pura Dermatology, we strive to provide our patients with the best and most up to date available medical care. This requires prescribing the most effective medications, and making sure you receive them in the easiest and most cost-efficient way possible.

Due to increasingly onerous insurance rules and repeated changes in what is covered, our patients find that using in-network pharmacies that are specialized to give dermatology prescriptions to be both faster and more cost effective. Specialty pharmacies are well known for providing support above and beyond what you will find at your local retail pharmacy. Such services include the processing of coupons and prior authorizations to ensure the best copay possible, insurance assistance, wider availability of specialized products, and free delivery to your home or other location of your choice and in-depth knowledge of insurance barriers and dermatology medications.

We have no connection, financial or otherwise, with any specialty pharmacies, but we find our patients receive better service and reduced pricing when filling prescriptions through this type of channel.

Dr. Lodha will determine the best medication and pharmacy for your unique needs. If you are comfortable with allowing us to choose which pharmacy your prescriptions will be sent to, please indicate below. If you would prefer to use a conventional pharmacy, please provide your pharmacy information.

___ Yes, please send my prescriptions to an in-network pharmacy.

___ No, I prefer to use the following pharmacy

Pharmacy name: _____

Telephone: _____

FAX: _____

Address: _____

Pharmacy hours: _____

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Additional Services

At Pura Dermatology, we offer variety of services. Please let us know what additional services you would like to learn about.

- ☐ Skin Care Advice
- ☐ Skin care products
- ☐ BOTOX Cosmetic/ Dysport
- ☐ Restylane
- ☐ Facial fine lines/ wrinkles
- ☐ Thin lips
- ☐ Blotchy skin
- ☐ Chemical Peels
- ☐ Red Veins on the Face or Body
- ☐ Facial redness/ red spots
- ☐ Length/ fullness of eyelashes
- ☐ Brown Spots/ age spots/ freckles
- ☐ Stubborn fat
- ☐ Sculpsure
- ☐ Facial resurfacing
- ☐ Skin tightening
- ☐ Non surgical face lift
- ☐ Body contouring
- ☐ Fat reduction
- ☐ Laser lipolysis
- ☐ Acne scars treatment
- ☐ Threading/ Thread lifting

☐ I'm not interested in any additional services at this time.