PuraDermatology

General Intake Form

Last Name ______________________ **First Name** ______________________ **DOB** ___/___/____

Addres____**Apt** ________________

City ____________________________ **State** __________________ **Zip Code** _____________

Cell Phone (____) _______-__________ **Home Phone** (____) _______-__________

Email ____ **Sex:** ☐Male ☐ Female

Race ☐ White ☐ African American ☐ Asian/ Pacific Islander ☐ Hispanic ☐ Other _______________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

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

Last Name: ____________________ First Name: ____________________ DOB: ___/___/___

Cell Phone: ____________________ Email: ___________________________________

In Case Of An Emergency, Please Notify:

Contact Name __________________________ Relationship to Patient __________________

Contact Cell Phone (____) ______-________ Home Phone (____) _______-__________

Preferred Pharmacy (Full Address & Phone #:) ____

____

☐ Send my prescriptions to an in-network pharmacy (Home Delivery Service)

Referred By ☐ Family/Friend ☐ Insurance ☐ ZocDoc ☐ Internet ☐Doctor_________________

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**

446 West 38th Street New York, NY 10018
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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. 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.

Cosmetic/ 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 that I am more than 15 minutes late to my appointment, or fail to change/ reschedule my appointment 24 hours in advance.

*There is no fee if the appointment is canceled or rescheduled 24 hours in advance.

______________________________ ____________________

Signature of Patient/Parent Date