Diana S. Leu, MD

Dermatology

601 Hamburg Turnpike, Suite 211, Wayne, NJ 07470

Phone: 973-925-7077 Fax: 973-925-7078

❖ PATIENT INFORMATION

Name (Last, First, Middle):_____ Date:_____

Date of birth:_____ Soc. Sec. #:_____ Home phone:_____

Address:_____ Cell phone:_____

City:_____ State:_____ Zip:_____ Sex: ☐ M ☐ F

E-mail address (for appointment reminders only):_____

Preferred language: _____

Race: ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ Unknown ☐ Decline response

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown ☐ Decline response

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated **Check if minor** (less than 18): o

How did you learn about the practice?_____

Primary care physician/referring doctor:_____

Occupation:_____ Employer:_____

Employer address:_____ Business phone: _____

❖ EMERGENCY CONTACT

Home phone:_____

Name:_____ Relationship to patient:_____ Cell phone:_____

❖ ADDITIONAL INSURANCE INFORMATION

***If the patient is not the policyholder**, please enter the following information **for the policyholder**.*
This applies to: Primary Insurance ☐ Secondary Insurance ☐

Policy holder's name (Last, First, Middle):_____ Relationship to patient:_____

Insurance policy # for policy holder: Check if same as that for patient ☐_____

Soc. Sec. #:_____ Birth date:_____ Home phone:_____

Address: Check if same as above ☐_____

❖ ASSIGNMENT, RELEASE, AND PATIENT'S FINANCIAL RESPONSIBILITIES

I hereby authorize insurance benefits to be paid directly to Diana S. Leu, MD LLC. I understand that I am financially responsible for any balance, including co-payments, deductibles, and co-insurance. Co-payments are expected at the time of the visit.
I also authorize the doctor and staff at this office to release any information required to my insurance companies to process my claims.
I authorize the use of my signature on all insurance submissions; a photocopy may be substituted for the original.

Signature:_____ Date:_____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above and fill in the information below.

Parent/guardian name (print):_____ Relationship to patient:_____

❖ PHARMACY INFORMATION

Please provide as much information as possible for your pharmacy:

Name:_____ Phone number:_____

Address:_____

HISTORY AND INTAKE FORM

❖ **DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:** (please circle all that apply)

Anxiety	End Stage Renal Disease	Prostate Cancer
Arthritis	GERD/reflux of the esophagus	Radiation Treatment
Asthma	Hearing Loss	Seizures
Atrial fibrillation	Hepatitis, Type:____	Stroke
Benign prostatic hypertrophy	High blood pressure	Crohn's Disease
Bone Marrow Transplantation	HIV/AIDS	Glaucoma
Breast Cancer	Hypercholesterolemia	Liver Disease
Colon Cancer	Hyperthyroidism	Lupus
COPD/emphysema	Hypothyroidism	Multiple Sclerosis
Heart disease	Leukemia	Psychiatric Care
Depression	Lung Cancer	Ulcerative Colitis
Diabetes	Lymphoma	Cancer not listed above:

Other _____

❖ **PAST SURGICAL HISTORY**: (please list)

_____

❖ **SKIN DISEASE HISTORY**: (please circle all that apply)

Precancerous sunspots	Hay Fever/Allergies	Squamous Cell Skin Cancer
Basal Cell Skin Cancer	Melanoma	Keloids/thickened scars
Blistering Sunburns	Precancerous Moles	Other_____
Eczema	Psoriasis	

Do you have a family history of Melanoma? Yes☐ No☐
If yes, which relative(s)? _____

Do you use sunscreen? Yes☐ No☐
Do you tan in a tanning salon? Yes☐ No☐

❖ **MEDICATIONS**: *Check if none* ☐ _____

_____

❖ **ALLERGIES TO MEDICATIONS**: *Check if none* ☐ _____

❖ **PLEASE ANSWER THE FOLLOWING (PLEASE CHECK YES OR NO):**

Do you have a pacemaker or defibrillator?	Yes☐	No☐
Do you require premedication with antibiotics prior to procedures?	Yes☐	No☐
Do you have an allergy to adhesive?	Yes☐	No☐
Do you have an allergy to antibiotic ointment?	Yes☐	No☐
Do you have an allergy to lidocaine/numbing agents?	Yes☐	No☐
Do you get a rapid heart beat with epinephrine?	Yes☐	No☐

❖ **SOCIAL HISTORY**: (Please circle)

Cigarette use: Currently smoke - daily
Currently smoke - not daily
Smoked in the past
Never smoked

❖ **ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS? (PLEASE CHECK YES OR NO)**

	Yes	No		Yes	No
Changing mole	☐	☐	Shortness of breath	☐	☐
Bleeding tendency	☐	☐	Sore throat	☐	☐
Fever or chills	☐	☐	Excessive thirst	☐	☐
Chest pain	☐	☐	Headaches	☐	☐
Cough	☐	☐	Blurry vision	☐	☐
Hay fever	☐	☐	Anxiety	☐	☐
Joint pain	☐	☐	Depressed mood	☐	☐
Frequent urination	☐	☐	Abdominal pain	☐	☐
Unintended weight loss	☐	☐			

Women only:
Are you pregnant? Yes☐ No☐
Are you planning a pregnancy? Yes☐ No☐

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, was given the opportunity to review a copy of
Patient Name
Diana S. Leu, MD's Notice of Privacy Practices. I understand a copy of the Notice of Privacy Practices is available upon my request.

Signature:_____ Date:_____

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Parent/guardian name (print):_____ Relationship to patient:_____

CONSENT FOR TELEPHONE MESSAGES AND SHARING HEALTH INFORMATION

I agree that telephone messages regarding my appointments, prescription renewals, lab results, and all other Protected Health Information may be left for me on voicemail systems and answering machines at any numbers provided to you by me.

- **Yes:** _____
- **No.** Please only leave information on this phone number's answering machine/voicemail:_____
- **No**, do not leave any information on my voicemail except appointment reminders:_____

I agree that my Protected Health Information may be shared with the following individuals:

- **Spouse:** Yes:_____ No:_____
- **Other individuals:**

_____

Signature:_____ Date:_____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above and fill in the information below.

Parent/guardian name (print):_____ Relationship to patient:_____

- I understand that I can change any of the foregoing agreements at any time by giving written notice to Diana S. Leu, MD

MEDICAL ADVISEMENT

Please note that Diana S. Leu, MD advises full skin examinations yearly for the purpose of skin cancer screening for all adults. We encourage you to make an appointment. If you have a history of skin cancer, more frequent full skin examinations may be advised.