

Diana S. Leu, MD

Dermatology

330 Ratzler Road, Suite D17, Wayne, NJ 07470
Phone: 973-925-7077 Fax: 973-925-7078

❖ PATIENT INFORMATION

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

Date of birth: _____ Home phone #: _____

Address: _____ Cell phone #: _____

City: _____ State: _____ Zip Code: _____ Gender: M F

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

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

How did you learn about the practice? _____

Primary care physician: _____ Phone # (if known): _____

Referring doctor (if applicable): _____ Phone # (if known): _____

Occupation: _____ Employer: _____

❖ EMERGENCY CONTACT

Name: _____ Relationship to patient: _____

Primary phone #: _____ cell home Secondary phone #: _____ cell home

❖ ADDITIONAL INSURANCE INFORMATION

If the patient is NOT the policyholder, please enter the following information for the policyholder.

This applied to: Primary Insurance Secondary Insurance

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

Relationship to patient: _____ Date of birth: _____

Insurance policy # for **policyholder**: Check if same as for that of patient _____

Address: Check if same as above _____

Primary phone #: _____ cell home Secondary phone #: _____ cell home

❖ 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 balances, 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.

When Dr. Leu is considered in-network by your insurance company, this does not necessarily mean that the insurance company will cover all costs after your co-payment. Once the insurance company is billed, we are finding that many insurance companies are now charging deductibles and/or co-insurances that are the patient's obligation for covered, insurance-eligible portions of their office visit. This may be in addition to your co-payment. If deductible or co-insurance is assigned by your insurance company, it will be billed to you after the office visit.

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

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

❖ PHARMACY INFORMATION Please provide as much information as possible for your pharmacy:

Pharmacy name: _____ Pharmacy phone #: _____

Pharmacy address: _____

Name: _____

HISTORY AND INTAKE FORM

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

Anxiety	End Stage Renal Disease	Prostate Cancer
Arthritis	GERD/efflux 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	High Cholesterol	Glaucoma
Breast Cancer	HIV/AIDS	Liver Disease
Colon Cancer	Hyperthyroidism	Lupus
COPD/Emphysema	Hypothyroidism	Multiple Sclerosis
Heart Disease	Leukemia	Psychiatric Care
Depression	Lung Cancer	Ulcerative Colitis
Diabetes	Lymphoma	Cancers not listed above:
Other _____		

❖ **PAST SURGICAL HISTORY:** (please list) *Check if none*

❖ **SKIN DISEASE HISTORY:** (please CHECK 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 <input type="checkbox"/> No <input type="checkbox"/>
Do you require premedication with antibiotics prior to procedures?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have an allergy to adhesive?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have an allergy to antibiotic ointment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have an allergy to lidocaine/numbing agents?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you get a rapid heart beat with epinephrine?	Yes <input type="checkbox"/> No <input type="checkbox"/>

❖ **SOCIAL HISTORY:** (Please check if applies)

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	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Fever or chills	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Blurry vision	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	Depressed mood	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Unintended weight loss	<input type="checkbox"/>	<input type="checkbox"/>			

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: _____

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: _____

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.