Diana S. Leu, MD

Dermatology

330 Ratzer 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 RESPONSIBILIES

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

Parent/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 ☐
Arthritis ☐
Asthma ☐
Atrial Fibrillation ☐
Benign Prostatic Hypertrophy ☐
Bone Marrow Transplantation ☐
Breast Cancer ☐
Colon Cancer ☐
COPD/Emphysema ☐
Heart Disease ☐
Depression ☐
Diabetes ☐
End Stage Renal Disease ☐
GERD/eflux of the esophagus ☐
Hearing Loss ☐
Hepatitis, Type:____ ☐
High Blood Pressure ☐
High Cholesterol ☐
HIV/AIDS ☐
Hyperthyroidism ☐
Hypothyroidism ☐
Leukemia ☐
Lung Cancer ☐
Lymphoma ☐
Prostate Cancer ☐
Radiation Treatment ☐
Seizures ☐
Stroke ☐
Crohn's Disease ☐
Glaucoma ☐
Liver Disease ☐
Lupus ☐
Multiple Sclerosis ☐
Psychiatric Care ☐
Ulcerative Colitis ☐
Cancers not listed above:
Other _____

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

_____

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

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

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 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	☐	☐	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:_____

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.