Welcome to Our Office

ALAN L. SCHECHTER, M.D., PH.D.
LISA M. SILBRET, M.D.

PATIENT INFORMATION

Name:______________________________ Sex:__________ Marital Status:__________

Address:______________________________ Town:__________________ Zip:__________

Home Phone:__________________Cell Phone:__________________ Work Phone:__________________

Date of Birth:______________________________ Patient's Social Sec. #:______________________________

How Did You Hear Of Us?____

Person Responsible for Billing:______________________________ Relationship__________________

Address:____

INSURANCE INFORMATION

Primary Coverage Carrier:____

Policy #:____ Relationship: Self/ Spouse / Child

Supplementary Coverage Carrier:____

Policy #:____ Relationship: Self / Spouse / Child

If the Insurance is in Someone Else's Name, Please Complete:

Name of Insured:______________________________ Soc. Sec. #:______________________________

Address (if different):____

Telephone (if different):______________________________ Relationship:__________________

EMPLOYMENT INFORMATION

Patient's Employer: ____

Address:____

Occupation:____

Spouse / Parent's Employer:____

Address:______________________________ Work Phone:__________________

I Authorize the release of medical information as required. I further authorize the release of any medical information necessary to process claims for my benefits from insurance. I authorize payment of benefits to be made direct to Alan L. Schechter, M.D., Ph.D., for services rendered

______________________________ ______________________________

Date

Signature of Patient
Signature of Parent if Patient is a Minor

ALAN L. SCHECHTER, M.D., PhD.
LISA M. SILBRET, M.D.

NAME______________________________

TODAY'S DATE______________________________

HISTORY

Have you or anyone in your family had:

	PATIENT		FAMILY	
High Blood Pressure	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No
Heart Disease	Yes	No	Yes	No
Pacemaker	Yes	No	Yes	No
Kidney Disease	Yes	No	Yes	No
Glaucoma	Yes	No	Yes	No
Liver Disease	Yes	No	Yes	No
Mononucleosis	Yes	No	Yes	No
Fainting	Yes	No	Yes	No
Ulcers	Yes	No	Yes	No
Hepatitis (Yellow Jaundice)	Yes	No	Yes	No
Rheumatic Fever	Yes	No	Yes	No
Thyroid Disease	Yes	No	Yes	No
Hormone Problems	Yes	No	Yes	No
Tuberculosis	Yes	No	Yes	No
Bleeding Problems	Yes	No	Yes	No
Nervous Conditions	Yes	No	Yes	No
Genetic Disorder	Yes	No	Yes	No
Other Serious Illnesses	Yes	No	Yes	No

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Other Skin Disorders

	PATIENT		FAMILY	
Do you form excessive scar tissue (keloid)	Yes	No	Yes	No
Eczema	Yes	No	Yes	No
Psoriasis	Yes	No	Yes	No
Hives	Yes	No	Yes	No
Hay Fever	Yes	No	Yes	No
Asthma	Yes	No	Yes	No
Moles Removed	Yes	No	Yes	No
Skin Cancer - location and type, if known	Yes	No	Yes	No

____

____

Melanoma	Yes	No	Yes	No

Prescription Plan Yes No

Are you now pregnant or planning pregnancy in the near future Yes No

List Medications presently being taken orally:

____

____

____

____

____

____

____

List Medications presently being applied topically to skin:

____

____

____

____

____

____

Allergic Reaction to Medication:

Novacaine	Yes	No
Sulfa	Yes	No
Penicillin	Yes	No
Aspirin	Yes	No

Other - please list all:

____

____

____

Use of sunscreen Yes No

If Yes, what SPF?______________

Hospitalization and/or Surgery:

Date ________ Reason ______________________

Date ________ Reason ______________________

Date ________ Reason ______________________

Date ________ Reason ______________________

Date ________ Reason ______________________

Were you referred by a physician Yes No

If so, whom?______________________

Reason for Today's Visit:____

____

____

ALAN L. SCHECHTER, M.D., PhD.
LISA M. SILBRET, M.D.

HIPAA PRIVACY ISSUE ACKNOWLEDGEMENT

I, ______________________________, acknowledge that I have read a
PRINT NAME
copy of Alan Schechter's, M.D., PhD. Privacy Notice.

____
Patient's Signature

Please choose one of the two options below:

I, ______________________________, hereby give your office permission
PRINT NAME
to leave biopsy results or any other medical results on my home telephone answering machine or to whomever answers the telephone at my home.

I, ______________________________, DECLINE to give your office
PRINT NAME
permission to leave biopsy results or any other medical results on my home telephone answering machine or to whomever answers the telephone at my home.

Signature: ______________________ Dated: __________________

Mount Sinai

Alan L. Schechter, M.D., PhD.
Lisa M. Silbret, M.D.

Cultural Competency:

State of New Jersey mandates that every physicians document any barrier to care including cultural and linguistic needs in the medical record. Factor affecting care are visual or auditory factors which may impede the member's ability to comprehend medical discussion. Language, cultural and/or religious customs, which may impact the provider's ability to provide medical care. Addressing these needs will improve patient satisfaction and also decreasing health care disparities. When documenting cultural competency in the member's medical record, it's imperative to document if no barriers exist.

Do you have any impairment: (i.e. Visual, hearing, speech, learning, physical and language/cultural
barrier.)

What language do you speak, read or write?

Do you have any religious or culture customs that the doctor should know about?
Yes No
If yes, please describe.

Do you have "Living Will' or advance Directives?
Yes No

Patient's 12 years of age and older

Do you smoke	Yes	No
Do you drink alcohol	Yes	No
Do you use street drugs	Yes	No

Patient's Signiture:______________________________Date:____________