

# COSULICH DERMATOLOGY

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## PATIENT DEMOGRAPHIC FORM

TODAY'S DATE: \_\_\_\_\_

Please complete this form to ensure proper billing of your services.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
First Last

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Email (for your patient portal): \_\_\_\_\_

Street Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Preferred Phone #: \_\_\_\_\_ HOME MOBILE Alternate Phone #: \_\_\_\_\_ HOME MOBILE WORK

### **Emergency Contact Information**

Emergency Contact Name: \_\_\_\_\_ Relationship to You: \_\_\_\_\_

Best Contact # for Emergencies: \_\_\_\_\_

### **Primary Care Information**

Primary Care Physician: _____	Ref. Physician (if different): _____
Address (street): _____	Address (street): _____
City, State, Zip: _____	City, State, Zip: _____
Telephone #: _____	Telephone: _____

Send diagnostic letters to Primary/Referring Physician, if necessary?:  Yes  No

### **Insurance Information**

Policy Holder's Name: \_\_\_\_\_

Your Relationship to Policy holder (or write SELF): \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_

PRIMARY Insurance Carrier: \_\_\_\_\_ SECONDARY Insurance Carrier: \_\_\_\_\_

Member ID #: \_\_\_\_\_ Member ID #: \_\_\_\_\_

**COSULICH DERMATOLOGY, LLC**  
**PATIENT DEMOGRAPHIC FORM**

**Electronic Communications**

**Patient Portal:** For your convenience, our practice offers secure electronic communications between you and your office via the Patient Portal. Secure messages and information can be read only by someone who knows your password to log in to the Portal site. The communications are automatically encrypted and, for those who want to participate, this secure communication can be a valuable tool to provide administrative and clinical information.

- Yes, I want to participate using my email provided on Page 1.
- No, I do not wish to participate at this time and decline online access to my clinical notes, results, and the ability to exchange messages via the portal.

**Appointment Reminders:** As an added convenience, we offer appointment reminder phone calls and texts via an automated service. The reminders are sent using a software service and cannot be used as a way for you to communicate back to us. Should you need to reach us, please call our main number (732-280-1200). If at any time you change your mind about reminders, please let us know or simply opt out by following the prompts in the voice calls or texts.

I understand under the Telephone Consumer Protection Act, that in order for the practice to contact me for services related to my medical care, Cosulich Dermatology, LLC and/or its agents may contact me by phone, including my cell phone, which may result in charges to me. Methods of contact may include prerecorded/artificial voice messages and/or use of an automated dialing device, as applicable.

- Yes, I want to participate. Phone #: \_\_\_\_\_
- No, I do not wish to participate at this time and decline any reminders for my future appointments.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Additional Information**

Which category best describes your racial background?

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Unreported/Refuse to Report

Ethnicity: How would you describe your ethnicity, such as your family background or ancestry?

- Hispanic or Latino
- Not Hispanic or Latino
- Unreported/Refuse to Report

Preferred language: What language do you usually speak at home?

- English
- Spanish
- Other \_\_\_\_\_

Whom can we thank for referring you to our practice?

- Health Insurance
- Social Media
- Google/Other Search Engine
- ER/Hospital/Doctor
- Newspaper/Magazine
- Other Patient \_\_\_\_\_
- Other \_\_\_\_\_



**COSULICH DERMATOLOGY, LLC**  
**FINANCIAL POLICY**

Welcome to Cosulich Dermatology, LLC, where we are fully committed to giving you the best care possible. We thank you for choosing our practice as your dermatology specialist. Please continue reading and sign below to acknowledge your understanding of our authorization for treatment, payment, and patient financial policies.

***Authorization for Treatment and Payment of Medical Benefits***

I give permission to Cosulich Dermatology, LLC to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to the practice.

***Use of Photography***

I agree that any photo identification and photos of spot and lesion sites taken at the time of my appointment will be considered a part of my medical record and will be used solely for the purpose of my treatment and medical care.

***e-Prescription Consent for Medication History***

We may request and use your prescription medication history information from your pharmacy using our e-prescription feature. This is only for informational purposes so that an up-to-date record of your medication is available for your treatment and safety.

- Yes, I consent to obtain my medication history using the e-Prescribing feature.
- No, I do not consent. I understand that my medication information may not be complete when making treatment decisions.

***Patient Financial Responsibilities***

- I (or patient’s guardian) understand that I am ultimately responsible for the payment of my treatment and care, including Lab/Pathology fees, which are separate from normal Practice fees.
- Cosulich Dermatology will assist me by billing my contracted insurers. However, I understand that I am required to provide the office with the most correct and updated information for my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated. I understand that if I need a referral, it is my responsibility to contact my primary doctor for the referral prior to my Cosulich Dermatology appointment. I understand that any bills resulting from not obtaining the required referral are my responsibility as the patient.
- I understand that I am responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by my insurance plan. I understand payment is due at the time of service, payable by cash, check, and most major credit cards, including HSA and FSA cards.
- I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include, but are not limited to:
  - Charge for returned checks
  - Charge for the copying and distribution of patient medical records
  - Charge for forms the practice fills out on your behalf
  - Charge for missed appointments

***Patient Authorizations***

I hereby authorize Cosulich Dermatology, LLC to release medical and other information to the necessary insurance companies and third party payers required for payment of rendered health services. I hereby authorize assignment of financial benefits directly to Cosulich Dermatology, LLC. I understand that I am financially responsible for charges not covered or denied, in full or in part, by my insurance plans.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

COSULICH DERMATOLOGY, LLC  
**HEALTH HISTORY & INTAKE FORM**

**Past Medical Conditions:**

**NONE**

Anxiety  
Asthma  
Atrial fibrillation  
Cerebrovascular accident (Stroke)  
Chronic obstructive lung disease  
Coronary arteriosclerosis  
Depressive disorder  
Diabetes mellitus  
Elevated blood pressure  
End-stage renal disease  
Human immunodeficiency virus infection  
Hypercholesterolemia (High cholesterol)  
Hyperthyroidism  
Hypothyroidism  
Inflammatory disease of liver  
Leukemia  
Malignant lymphoma (clinical)  
Malignant tumor of colon  
Radiation therapy treatment management  
Transplantation of bone marrow

Other: \_\_\_\_\_

**Past Surgical History:**

**NONE**

Coronary artery bypass graft  
Entire transplanted kidney  
History of tissue graft heart valve replacement  
Hysterectomy  
Mechanical heart valve replacement  
Splenectomy  
Total replacement of left hip joint  
Total replacement of left knee joint  
Total replacement of right hip joint  
Total replacement of right knee joint  
Transplantation of heart  
Transplantation of liver

Other: \_\_\_\_\_

**Skin Disease History:**

**NONE**

Acne	History of hay fever
Actinic Keratosis	Malignant melanoma
Basal cell carcinoma of skin	Pruritis of scalp
Contact dermatitis due to poison ivy	Psoriasis
Dysplastic nevus of skin	Squamous cell carcinoma
Eczema	Sunburn of second degree
History of asthma	

Other: \_\_\_\_\_

COSULICH DERMATOLOGY, LLC  
**SKINCARE & MEDICATIONS INFORMATION**

Reason for today's visit: \_\_\_\_\_

**Skincare Questionnaire**

Do you wear sunscreen regularly?  Yes, I use SPF \_\_\_\_\_  Not Currently

Do you tan in a tanning salon?  Yes  No

Do you have a family history of Melanoma?  Yes \_\_\_\_\_  No

Are you currently taking any medications?  Yes, see below  NONE

Do you have any allergies to medications?  Yes, see below  NONE

**Medications**

Name of Medication <small>(include all over-the-counter &amp; herbal supplements)</small>	Dose <small>(mg, mcg, tablet, etc.)</small>	Frequency <small>(1x day, 2x day, 1x wk, as needed, etc.)</small>	Last Time Taken

**Allergies to the following medications:**

\_\_\_\_\_ Reaction: \_\_\_\_\_

\_\_\_\_\_ Reaction: \_\_\_\_\_

\_\_\_\_\_ Reaction: \_\_\_\_\_

**Smoking & Alcohol History:**

**Cigarette smoking:**      Never smoked      Quit – former smoker      Less than once/day      Daily

**Alcohol use:**      Non-drinker      Fewer than once/day      1–2 drinks      3+ drinks/day

**How many times *in the past year* have you had 5 or more drinks (for men), or 4 or more drinks (for women/adults over 65)?** \_\_\_\_\_

**Illicit drug use:**      Never used      IV drug use      Other

COSULICH DERMATOLOGY, LLC  
**HEALTH ASSESSMENT FORM - 2023**

In accordance with CMS government guidelines (PQRS – Physician Quality Reporting System), we are required to obtain *annual* overall health assessments on our patients.

Print Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Fall Risk Assessment**

Have you had any falls in the past year?       No       Yes

If yes, how many falls in the past year?

If yes, were you injured?     No       Yes

If injured, describe injury below:

I do not wish to discuss this matter

**Vaccination Screening**

Have you had a flu vaccine this season?     No       Yes

If yes, date of vaccination (MM/YY): \_\_\_\_/\_\_\_\_

If no, reason:

\_\_\_ Recommended but not administered

\_\_\_ Refused – Do not want vaccine

\_\_\_ Allergic to flu vaccine

If you are **over** 65 years of age, have you ever had the pneumococcal vaccination?     No       Yes \_\_\_\_\_ (YYYY)

I do not wish to discuss this matter

**Diabetic Patient Screening**

Are you diabetic?     No       Yes

If yes, what is your Hemoglobin A1C?     Less than 7       Between 7 and 9       Greater than 9       Unsure

I do not wish to discuss this matter

**Advance Directive (Living Will)**

If you are 65 or over, do you have an advance directive (living will)?     No       Yes

If yes, please write the name of your Proxy (individual authorized to make medical decisions on your behalf – usually a spouse or child): \_\_\_\_\_

If no, would you like more information?     No       Yes       I do not wish to discuss this matter

**COSULICH DERMATOLOGY, LLC**  
**MEDICAL CONCERNS & PHARMACY INFORMATION**

**Review of Symptoms and Alerts**

Do you currently experience or have any of the following? **Check Yes or No for each.**

SYMPTOMS	YES	NO
Problem with bleeding		
Problem with healing		
Problem with scarring (hypertrophic or keloid)		
Changing mole		
Rash		
Anxiety		
Depression		
Fever or chill		
Headache		
Hay fever		
Joint aches		
Muscle weakness		
Neck stiffness		
Thyroid problem		
Unintentional weight loss		

ALERTS	YES	NO
Pacemaker		
Defibrillator		
Artificial joints within past 2 years		
Artificial heart valve		
Premedication prior to procedure		
Allergy to adhesive		
Allergy to topical antibiotic ointments		
Blood thinners		
Pregnancy or planning a pregnancy		
Allergy to lidocaine		
Rapid heartbeats with epinephrine		
Yeast infections with antibiotics		
GI upset with antibiotics		
Carbocaine only		

**Pharmacy Information**

Pharmacy Name: \_\_\_\_\_ Select One:    Local        Mail Away  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_