DERMATOLOGY, LASER SURGERY AND SKIN SURGERY-----BOARD CERTIFIED

Name Mr./ Ms./ Mrs. _____Birthdate____/____/____ Age ____Today's Date____/____/____
First Middle Initial Last
Street Address _____Apt #_____City _____State _____Zip_____
Occupation_____Employer_____
Business Address_____City_____State_____Zip_____
Social Security #_____-_____-_____
Home Telephone #: (_____) _____ Work #: (_____) _____ Cell #:(_____) _____
Circle one: Single/Married/Divorced/Separated/Widowed Spouse/Partner's Name: _____
In an emergency contact_____
Name Work Phone Home Phone Relation
Referred by (circle or give name if known): Doctor_____; Patient_____; Internet (specify site) _____

MEDICAL/DERMATOLOGIC HISTORY

Do you or have you: (please circle)

Burn easily when exposed to the sun?……Yes/No
Had any sunburns that blistered?……Yes/No
Often go without sunscreen when sun exposed?…….Yes/No
Ever worked outdoors?……Yes/No
Been under additional stress lately?……Yes/No
Smoke regularly……..Yes/No
Exercise infrequently?…….Yes/No
Eat an unbalanced diet?…….. Yes/No

Do You or Does Anyone in Your Family:

Have asthma, eczema, hayfever, or hives?……...Yes/No
Have psoriasis?……Yes/No

Do You or Does Anyone in Your Family:

Have unusual appearing or numerous moles?…….….Yes/No
If so, whom?_____
Have skin cancer?……..…Yes/No
If so, which kind and whom, if known?_____

If Male, please skip this section --- For Women Only

Do you have irregular/absent menstrual cycles?…..….Yes/No
Are you on the birth control pill?……..... Yes/No
Have you had any vaginal yeast infections?……..... Yes/No
Are you planning a pregnancy?……..... Yes/No
Are you pregnant?…….…. Yes/No
Are you currently breastfeeding?…...…….…. Yes/No

Please inform the doctor immediately if you plan To become pregnant during your treatment.

1.Describe any recent travel _____ Hobbies_____
2.How long have you had this skin problem? _____ Any prior treatment and what kind?_____
3.Have you had other skin disorders? How were they treated? _____
4.Do you have difficulty with healing of wounds, keloids, or overgrown scars? _____
5.If you take medication, vitamins, drugs, over-the-counter (non-prescription) preparations, please list with dosages, if known: ____
_____
6.If you have had an allergic reaction to medications, anesthetics, or epinephrine, please list: _____
7.If you are currently in the care of an internist, GP or gynecologist; please list: _____
8.Any other information you feel will be helpful_____
9.Are you interested in ways to rejuvenate your skin and maintain a youthful appearance? _____
10.Would you like to receive information on advances in dermatology and promotions? Yes__ No___
May we contact you via e-mail? Yes__ No___ If yes, please provide us with your e-mail: _____

May we connect with you on social networks? Yes___ No___ If yes, please provide your contact information below:
Facebook _____ Twitter _____ LinkedIn_____
Your Signature: _____ Date_____

MEDICAL INSURANCE INFORMATION

Do you have Medicare? Yes_____ No_____
Insurance company name and address_____
Who is the subscriber? (name on insurance ID care or name of policy holder) _____
Policy (certificate ID#) _____ Group name (if applicable) _____ Group #_____
Does your insurance cover prescriptions? YES, I have a card_____; YES, I get reimbursed_____; No_____; Do not know_____
Who is financially responsible for today's bill? _____; Payment will be made in: Cash____ Check___ Credit Card_____

As a non-participating physician ("out-of-network"), I have not agreed to any set rate that your health care plan may pay, and I may charge more. If unforeseen medical circumstances arise when the services are provided, the amount that will be billed for the services maybe higher.

I am providing you the following information to help you to understand what your health care plan may not cover if you obtain services from an out-of-network physician. Your plan may not cover out-of-network services at all, leaving you to pay the full cost.

If your plan covers out-of-network services your plan may require higher co-pays, deductibles, and co-insurance for out-of-network care. You will have to pay these higher amounts plus any difference between your plan's allowed amount and what the out-of-network physician charges for the services.

The patient acknowledges that Stephen L. Comite, M.D. is an out-of-network physician but has elected to obtain the services from Dr. Comite.

Acknowledgment of Patient: Signature _____ Date: _____
If Legal Representative, indicate relationship to patient _____
Print Name of Patient _____
Print Name of Legal Representative _____

Assignment of Benefits/Release of Information

I authorize the release of any medical information necessary to process this claim and I authorize payment of medical benefits to the named provider for professional services rendered.

Your Signature _____Date_____