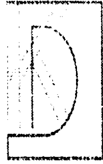


K DERMATOLOGY
& AESTHETIC CENTER

NEW PATIENT REGISTRATION

NAME:______________________________DOB:________

Gender: M F Non-Binary prefer not to answer

MARITAL STATUS: S M D W

PHONE:______________________________
ALT. PHONE:__________________________

OK TO LEAVE MESSAGES? Y N

EMAIL:________________________________
ADDRESS:_____________________________
CITY_________________STATE____________ZIP______

ETHNICITY:___________________________
PREFERRED LANGUAGE:______________
SOCIAL SECURITY #__________________

PRIMARY CARE DOCTOR: ________________________________

HOW DID YOU HEAR ABOUT US?_________________

H istory and Intake Form

Patient's Name: ____

Birthday:________________

MM DD YYYY

Preferred PHARMACY NAME: ___________________________________

PHARMACY Phone #: ________________________

Pharmacy city or Zip code: ______________________

REASON FOR VISIT: _______________________________________

**Have you had your flu shot this season? [ ] yes [ ] no
Have you had your pneumonia vaccine? [ ] yes [ ] no [ ] N/A

Past Medical History: (please CHECK all that applies)

Anxiety Coronary Artery Disease Thyroid Problems Arthritis Depression Leukemia Asthma Diabetes Lung Cancer Atrial fibrillation End Stage Renal Disease Lymphoma Bone Marrow GERD Prostate Cancer Transplantation Hearing Loss Radiation Treatment Breast Cancer Hepatitis Seizures Colon Cancer High Blood Pressure Stroke COPD HIV/AIDS High Cholesterol NONE

Other____

Past Surgical History: (please CHECK all that applies)

Appendix Removed Joint Replacement within 2 years Bladder Removed Kidney Biopsy (Nephrectomy) Mastectomy (Right, Left, Bilateral) Kidney Removed (Right, Left) Lumpectomy (Right, Left, Bilateral) Kidney Stone Removal Breast Biopsy (Right, Left, Bilateral) Kidney Transplant
Breast Reduction Ovaries Removed: Endometriosis Breast Implants Ovaries Removed: Cyst Colectomy: Colon Cancer Resection Ovaries Removed: Ovarian Cancer Colectomy: Diverticulitis Prostate Removed: Prostate Cancer Colectomy:IBD Prostate Biopsy
Gallbladder Removed TURP (Prostate Removal) Coronary Artery Bypass
Spleen Removed
Mechanical Valve Replacement Testicles Removed (Right, Left, Bilateral) Biological Valve Replacement Hysterectomy: Fibroids Heart Transplant Hysterectomy: Uterine Cancer Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral) NONE
Other: ____

Skin Disease History: (please CHECK all that applies)

Acne
Actinic
Keratoses
Asthma
Basal Cell Skin
Cancer Blistering

Sunburns
Dry Skin
Eczema
Flaking or Itchy
Scalp Hay
Fever/Allergies
Melanoma

Poison Ivy
Precancerous
Moles Psoriasis
Squamous Cell Skin

Cancer NONE

Other____

Do you wear Sunscreen? Yes No If yes, what SPF?________
Do you tan in the tanning salon? Yes No

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)____

Medications: (Please enter all current medications)

____
____
____
____

Allergies: (Please enter all allergies)

____
____
____

Social History: (Please CHECK all that apply)

Cigarette Smoking: Alcohol Use:

Currently Smokes EtOH-None
Has smoked in the past EtOH- less than 1 drink a day Never smoked EtOH-1-2 drinks per day Former Smoker EtOH-3 or more drinks per day

ALERTS: (please CHECK all that applies)

Allergy to Adhesive Allergy to lidocaine Allergy to topical antibiotics Artificial heart valve
Artificial joint replacement Blood thinners Defibrillator MRSA Pacemaker Require antibiotics prior to surgical procedure
Rapid heart beat with epinephrine
Pregnant or currently trying to get pregnant NONE

Isn't it Time to Look & Feel Better?

Cosmetic Interest Questionnaire

Name: ____________________ E-mail address: _____________________ Phone:_____________________

We are constantly striving to offer you the safest, most advanced procedures for facial rejuvenation and overall skin health. Please check any of the following topics you would like to receive more information about.

- □ Fine Lines & Wrinkles
- □ Sagging skin
- □ Unwanted Hair
- □ BOTOX® Cosmetic
- □ Facial Volume Loss
- □ Skin Peels
- □ O shot
- □ Acne
- □ Microdermabrasion
- □ Skin Rejuvenation
- □ Brown Spots
- □ Leg Veins
- □ Juvederm/Voluma
- □ Lip Lines
- □ Age spots
- □ Tattoo removal
- □ Laser skin resurfacing
- □ Laser hair Removal
- □ Facial Redness

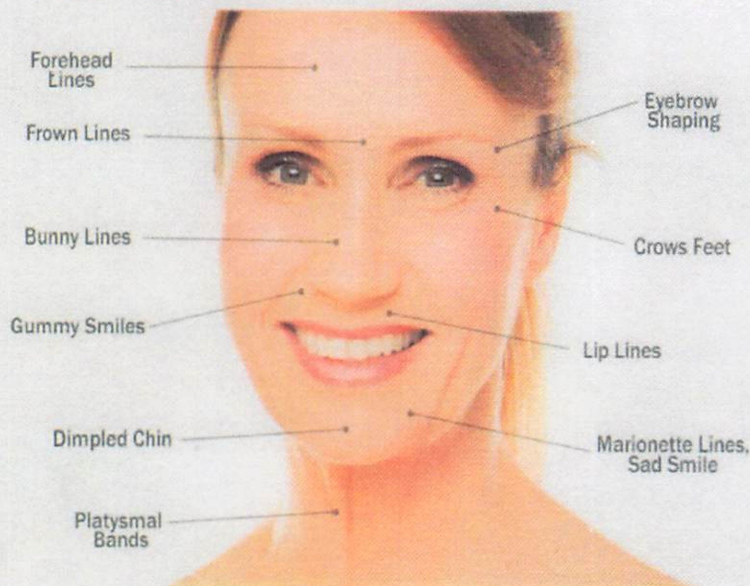
May we contact you with information about your expressed areas of interest? □Yes □No

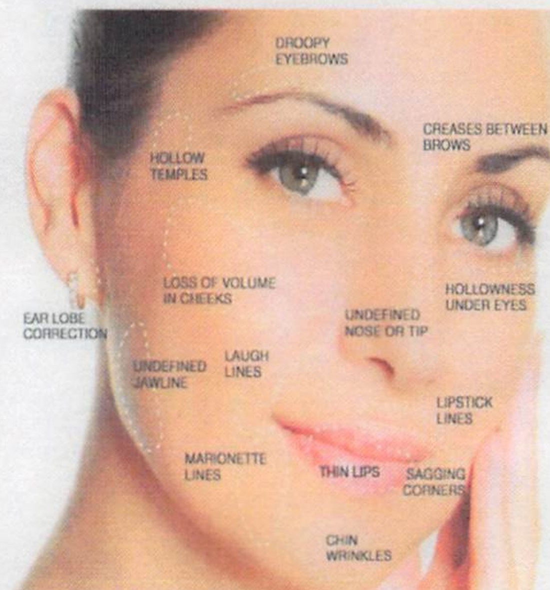
Would you like to schedule a consultation with our Skin Specialist? □ Yes □ No

I would like to be added to the email/mailing list to be informed of special events □ Yes □ No

How did you hear about our practice? (internet search, friend, Doctor) ______________________________.

Please circle areas of concern:





Financial Policies Payment

Your health coverage is a contract between you and your insurer, not the physician. Third party payers (commercial and government insurers) reimburse the physician according to a negotiated fee schedule. However, if issues arise, the patient is ultimately responsible for payment. As a courtesy to our patients, we will submit your claim to the insurer. You will then receive an EOB (explanation of benefits) in the mail/by email directly from your insurer detailing the amount you are required to pay, if any. We are now in the era of managed care. Insurance companies are concerned about the rising costs of healthcare. In an attempt to control their costs, they share the burden of paying for your healthcare with you. ***Please understand that we did not select your insurance plan. You will be responsible for any co-payments and/or deductibles or non-covered services specified by your insurer at the time of service. A deductible is the amount of money your insurance company requires you to pay before your plan "kicks in" and covers the rest. You should assume every procedure done in a dermatology office will be applied to your deductible. We reserve the right to collect deductibles and coinsurance up-front PRIOR to procedures. We are contractually obligated with your insurer to collect these charges. There are no exceptions.***

If your insurance requires a REFERRAL to see a specialist, it is your responsibility to ensure our office has that referral PRIOR to your visit. If we do not have a referral, your insurance will not cover the visit and you will be responsible for the cost of the visit. You will also be financially responsible if your health plan is not a plan our office participates in.

We accept payment in the form of cash, personal check, Visa, Mastercard, Discover and American Express. There is a $25 returned check policy.

Patients with Out of Network Coverage

If we are not a provider with your insurance plan, you are expected to pay 100% of the charges at the time service is rendered. A claim form will be given at the end of the visit to submit to your insurance company.

Pathology and Lab Fees

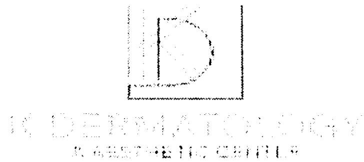
Diagnostic fees for skin biopsies or excisions are the patient's responsibility. Facilities our practice uses include DermPath to name a few. If you have questions about a bill received from one of these entities, you should call the phone number listed on the statement. We do not have the authority to discuss charges or your account balance with these laboratories.

Financial & Collections Policy

As a courtesy, we will file an insurance claim to any carrier we participate in for our services. In order to properly file or appeal a claim, we must have each patients' current valid insurance card. We will ask for this item when scheduling your first appointment. This ensures we have the most pertinent information on file and we can verify insurance eligibility prior to or on the date of service, thus helping make your visit more efficient.

In order to continue to provide outstanding medical care, we make every effort to collect money owed to our practice for previous treatment. All patient balances are due 30 days from receipt of the statement from our office, or at any follow up visits. If, after several attempts, we fail to collect the outstanding balance, you may be unable to schedule future appointments until that balance is paid in full.

PATIENT NAME:______________________________ SIGNATURE:______________________________



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required by State and Federal laws, including the HIPAA rules, to safeguard general health related information about you. We have a **Notice of Privacy Practices** that explains how your protected health information is handled and how we may use and/or disclose your protected health information. The Notice of Privacy Practices is provided to patients (and /or their authorized representatives) when they first become our patient and a copy of its available on our website:www.kdermnj.com

We are asking you to sign this form to show that we offered you a copy of our Notice of Privacy Practices. Personal copies can be requested from our staff. By signing below, you are only acknowledging that you were offered or received a copy of the Notice of Privacy Practices. You may refuse to sign this acknowledgement if you wish. You are not making any statements about the content of the Notice of Privacy Practices and about your agreement or disagreement with any portion of it.

Acknowledgement
I acknowledge that K Dermatology & Aesthetic Center LLC has offered or provided me with a copy of its Notice of Privacy Practices, which describes how medical information about me may be used and/or disclosed, and how I can access this information.

I understand if I have any questions or complaints I may contact the office 732-677-2049. I also understand that I am entitled to receive updates if K Dermatology & Aesthetic Center LLC amends or changes its Notice of Privacy Practices in a material way.

____

Signature of Patient / patient's representative

NO SHOW/CANCELLATION POLICY

We understand that there are times when you must miss an appointment due to emergencies or work and family obligations. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit due to a seemingly "full" appointment schedule.

Appointment Policy:

- A 24 hour notice is needed to cancel/change an appointment. If 24 hour notice is not given the following will apply:
  - Appointments for **examinations, consultations, evaluations, and checkups** will incur a $25 fee.
  - Appointments for **surgical procedures** will incur a $50 fee due to the large block of time set aside for the procedure.
  - Appointments for **cosmetic procedures** will incur a $100 fee due to the block of time and ordering of specific materials.

If you "no-show" for your appointment, you are responsible for the fees above.

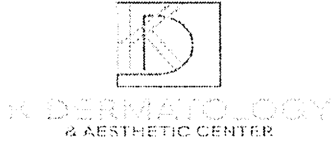
Any fees are charged to the patient and are **NOT** covered by insurance. Any fees are **due at the time of the patient's next office visit**.

By signing this form, the patient acknowledges that they have been informed of, and consent to the K Dermatology & Aesthetic Center, LLC cancellation policy.

__________________ Date

____
Print Patient Name

____
Patient/Guardian Signature



340 State Route 34 S, Suite 203
Colts Neck, NJ 07722

732-677-2049
drsairahkhokher@kdermnj.com

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION WITH DESIGNATED PARTIES

PATIENT'S NAME: ________________________ **DATE OF BIRTH:** ____________

I VOLUNTARILY REQUEST AND AUTHORIZE DR. SAIRAH KHOKHER AND THE STAFF OF K DERMATOLOGY & AESTHETIC CENTER, TO DISCUSS AND RELEASE HEALTHCARE INFORMATION OF THE PATIENT NAMED ABOVE TO THE FOLLOWING:

PLEASE DESINGATE FAMILY AND FRIENDS WITH WHOM WE CAN SHARE YOUR MEDICAL INFORMATION WITH:

DESIGNATED PARTY: ________________________ **RELATION TO PATIENT:** ____________

DESIGNATED PARTY: ________________________ **RELATION TO PATIENT:** ____________

DESIGNATED PARTY: ________________________ **RELATION TO PATIENT:** ____________

_____ **INITIAL: I understand that I can revoke this authorization at any time through a written request.**

_____ **INITIAL: I understand that my treatment cannot be contingent upon my signing of this authorization.**

________________________________ ________________

PRINT PATIENT REPRESENTATIVE'S NAME **DATE**

________________________________ ________________

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE **DATE**