SKIN AND LASER
SURGERY CENTER OF PENNSYLVANIA

1528 Walnut Street, Suite 1101 · Philadelphia, PA 19102 · 215.735.4994 · Fax: 215.735.8376

PATIENT REGISTRATION INFORMATION

Please print clearly. **Date** _____

How did you hear of our practice? [ ] Friend/relative [ ] Physician [ ] Internet [ ] Other _____

Name _____
(last) (first) (middle)

Address _____

City _____ **State** _____ **Zip Code** _____

( )Male / ( )Female Birthdate _____ **Race** _____

Mobile Phone (_____) _____ **Home Phone (_____)** _____

Social Security # _____ **Email Address** _____

Marital Status ( )Single ( )Married ( )Widowed ( )Divorced Maiden Name _____

Referring Physician or Referral Source _____

Referring Physician Address _____
(street address) (city, state, zip)

Primary Care Physician _____
(phone and fax number)

Primary Care Physician Address _____
(street address) (city, state, zip)

Your Occupation _____

Employer Name and Address _____
(name) (street address) (city, state, zip)

Emergency Contact

_____
(name) (relationship)

Person responsible for payment _____ **Phone (____)** _____
(parent/spouse)

Address _____
(street address) (city, state, zip)

Responsible Party's Employer _____ **Work Phone (____)** _____

Address _____
(street address) (city, state, zip)

HISTORY AND INTAKE FORM

Name: _____ **Date:** _____

Reason for today's visit: _____

Past Medical History: (please circle all that apply)

- None
- Anxiety disorder
- Arthritis
- Asthma
- Atrial fibrillation
- Benign prostatic hyperplasia
- Cerebrovascular accident
- Chronic obstructive lung disease
- Coronary arteriosclerosis
- Depressive disorder
- Diabetes mellitus
- Disease cause by 2019-nCov
- Elevated blood pressure
- End-stage renal disease
- Epilepsy
- Gastroesophageal reflux disease
- H/O: hypertension
- Hearing loss
- Human immunodeficiency virus
- Hypercholesterolemia
- Hyperthyroidism
- Hypothyroidism
- Inflammatory disease of liver
- Leukemia
- Malignant lymphoma
- Malignant tumor of breast
- Malignant tumor of colon
- Malignant tumor of lung
- Malignant tumor of prostate
- Radiation therapy treatment management
- Transplantation of bone marrow
- Other

Past Surgeries

- None
- Abdominoperineal resection
- Bilateral replacement of knee joints
- Biopsy of breast
- Biopsy of prostate
- Coronary artery bypass graft
- Entire transplanted kidney
- Excision of basal cell carcinoma
- Excision of melanoma
- Excision of squamous cell carcinoma
- H/O: colostomy
- H/O: tubal ligation
- History of bilateral mastectomy
- History of cholecystectomy
- History of colectomy
- History of liver excision
- History of percutaneous transluminal coronary angioplasty
- History of tissue graft heart valve replacement
- History of total cystectomy
- History of transurethral prostatectomy
- Hysterectomy
- Kidney biopsy
- Low anterior resection of rectum
- Lumpectomy of breast (left / right)
- Mastectomy (left / right / bilateral)
- Mechanical heart valve replacement
- Oophorectomy
- Pancreatectomy
- Percutaneous extraction of kidney stone with fragmentation procedure
- Portosystemic shunt operation
- Prostatectomy
- Prosthetic arthroplasty of bilateral hips
- Splenectomy
- Surgical biopsy of skin
- Total nephrectomy
- Total orchidectomy
- Total replacement of hip (left / right / bilateral)
- Total replacement of knee (left / right / bilateral)
- Transplantation of heart
- Transplantation of liver
- Other

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asteatosis cutis
Basal Cell Skin Cancer
Contact dermatitis due to poison ivy
Dysplastic nevus of skin
Eczema
H/O: asthma
H/O: hay fever
Malignant melanoma
Pruritus of scalp
Psoriasis
Squamous Cell Skin Cancer
Sunburn of second degree
Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma: Yes No
If yes, which relative(s)? _____

Any other family history? _____

Medications: (please list all current medications)

_____
_____
_____
_____
_____
_____

Allergies: (please list all allergies)

_____
_____
_____

Social History: (please circle one)

Smoking Status:
Current
Former
Never

Drinking:
Men: How many times in the past year have you had 5 or more drinks in one day? _____
Women & Adults 65 & over: How many times in the past year have you had 4 or more drinks in one day? _____

Language
English
Spanish
Other: _____

Race
White
Black/African American
Asian
American Indian or Native Alaskan
Native Hawaiian/Pacific Islander

Pharmacy Name:_____

Address: _____ Zip Code:_____

SKIN AND LASER
SURGERY CENTER OF PENNSYLVANIA

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Skin and Laser Surgery Center of Pennsylvania
1528 Walnut Street, Suite 1101
Philadelphia PA 19102
Tel: 215-735-4994 Fax: 215-735-8376

I am a patient of _____.

I hereby acknowledge receipt of The Skin and Laser Center of Pennsylvania's Notice of Privacy Practices.

Name (please print): _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____.

I hereby acknowledge receipt of The Skin and Laser Center of Pennsylvania's Notice of Privacy Practices with respect to the patient.

Name (please print): _____

Relationship to Patient: ( ) Parent ( ) Legal Guardian

Signature: _____

Date: _____

SKIN AND LASER
SURGERY CENTER OF PENNSYLVANIA

Dr. Jason H. Neustadter

1528 Walnut Street, Suite 1101
Philadelphia, PA 19102
Phone: 215.735.4994
Fax: 215.735.8376

Financial Policy

Thank you for choosing our office for your health care needs. We have some basic guidelines concerning insurance and financial requirements. These guidelines help us to control health care costs by reducing our billing and collection costs.

Payment Options

The law requires us to collect all co-payments and deductibles, which are collected at the time of service. If we do not collect payments, your insurance company can charge us with fraud. Please do not ask us to waive these requirements. You can pay by cash, check, or major credit card (Visa and Mastercard).

If you have a major medical plan, payment is expected on the day of your visit. Once payment is posted, we will give you a receipt containing all the information you will need to get reimbursed from your insurance company.

Payment Liability

If you have an HMO or Managed Care Insurance, then you are required to obtain a referral from your Primary Care Physician. It is your responsibility to understand and check with member services on co-pays, coinsurance, deductibles, referrals, and non-covered services.

If your referral is not obtainable through the Navinet System on the day of your appointment, then you will have an option to reschedule or waive your rights to not use your insurance for services rendered that day. If we are unable to retrieve a valid referral for the correct date of service, then you will be responsible.

Most insurances require an authorization for surgery. Please check with your insurance company or ask the Billing Office for more information regarding insurances that need an authorization prior to surgery. We will provide the diagnostic and procedure code for you to check if an authorization is required. We will obtain the authorization through your insurance company.

Laser treatments are considered to be a cosmetic procedure by most insurances. If you need a laser treatment for a medical reason, then you need to inform the billing office to contact your insurance for pre-determination. If you decide to receive a laser treatment without authorization, then you will be responsible if your insurance denies the claim.

We participate with many different insurance plans. Please check with our billing department to see if your insurance company is included. We will be glad to submit claims to your insurance company if you provide us with all necessary information. You are responsible for any part of your bill not paid by your insurance company. Your insurance company has 60 days to respond to our claim. If your carrier has not responded in 60 days, or if your claim is denied or partially paid, you will be responsible for the balance. We will do everything we can to assist you in getting payment from your insurance carrier.

If you are having financial troubles, please discuss them with our billing manager. Although we will work with you, we will not misrepresent any medical information to get reimbursed by your insurance company.

Your signature below will confirm that you have read and understand it is your responsibility for any balances that are due after billing your insurance or for treatments that were provided to you by one of our physicians or medical staff.

Signature: _____ **Date:** _____

SKIN AND LASER
SURGERY CENTER OF PENNSYLVANIA

Jason H. Neustadter, MD

1528 Walnut Street, Suite 1101
Philadelphia, PA 10102
Phone: 215.735.4994
Fax: 215.735.8376

Patient Screening Questionnaire

Name: _____ DOB: _____

Email: _____

1. **Drinking**

   Men:
   How many times in the past year have you had 5 or more drinks in one day?

   _____

   Women and Adults 65 and over:
   How many times in the past year have you had 4 or more drinks in one day?

   _____

2. **Smoking status**: ☐ Current
   ☐ Former
   ☐ Never

3. **Primary Care Physician**: _____

   Address: _____

   Phone: _____

4. **City and State of Birth:** _____