Last Name: _____ First Name: _____ Middle Name: _____

Address: _____ Apt#: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security Number: _____ Date of Birth: _____Age: ____ Country of Birth: _____

Marital Status: **Single Married Divorced Widowed Separated**

Please provide your e-mail address here: _____

I authorize the use of the above e-mail

Please provide a username _____ and desired password _____ to be used for accessing the patient portal at mandeldermatology.com.

For all notifications from this office: _____ _____

Patient Signature Date

Referring Physician Name: _____ Telephone: _____

Race: American Indian or Alaskan Native Asian Asian Indian Black or African American Native Hawaiian Other Pacific Islander White More Than One Race

Ethnic Group: Hispanic or Latino Non-Hispanic or Latino Decline to Report

Pref. Language: English Spanish Other _____

Local Pharmacy: _____

(Name/City/Phone)

Mail Order Pharmacy: _____

REASON FOR COMING TO THE DOCTOR TODAY:

Reason for Today's Visit: _____

Timing/Onset:

When did symptoms first occur? _____

Duration:

Frequency of symptoms: _____

Characterized as/ Severity:

Describe the severity of the symptoms/pain. _____

Associated Signs and Symptoms:

Are there any other symptoms associated with your problem? _____

Modifying Factors:

What makes the condition better and/or worse? _____

Is the condition better and/or worse during the spring, summer, fall, winter? _____

Vitals: Height: _____ Weight: _____

ALLERGY HISTORY:

No Known Allergy

___ Acetaminophen ___ Epinephrine ___ Latex ___ Penicillin

___ Aspirin ___ Erythromycin ___ Lidocane ___ Sulfur

___ Codeine ___ Ibuprofen ___ Metal ___ Tetracycline

___ Other:

Please list reaction with the allergy.

CURRENT MEDICATION:

I am not currently taking any medications.

List any medications, vitamins, minerals and herbals that you are currently taking:

___Retin-A ___Erythromycin ___ Minocycline ___ Triamcinolone ___ Desonide

___ Cleocin-T ___Doxycycline ___ Dovonex ___ Clobetasol

Name of Medication	Dosage	Name of Medication	Dosage

PAST MEDICAL HISTORY:

___ Anemia	___ Hepatitis	___ Hormone Deficiency	___ Skin Cancer
___ Arthritis	___ High Blood Pressure	___ Kidney Disease	___ Skin Rash
___ Diabetes	___ High Cholesterol	___ Liver Disease	___ Sun Burn
___ Digestive Disorder	___ HIV Disease	___ Low Blood Pressure	___ Thyroid Disease
___ Heart Disease	___Hives	___ Seizures	___ Vasovagal Episode (fainting)

List any other important medical condition(s) you have had (do not include common colds or flu). Include date of initial diagnosis if possible.

Problem/Previous Diagnosis *Date(s) or Age*

_____

_____

_____

Please describe your sun exposure history:

Little Moderate Excessive

Have you had any of the following?

Sun Burns Blistering Sun Burns Skin Cancer (type):_____

PAST SURGICAL HISTORY:

No Past Surgical History

Surgery Name Date Doctor Hospital

_____

_____

_____

_____

PREGNANCY/BIRTH HISTORY:

Male (skip this section) or Female

What is your current pregnancy status?

Pregnant (due date) _____ Nursing Planning Pregnancy (when) _____

Do you use birth control? Yes No

If yes, please indicate what type of birth control: _____

FAMILY HISTORY:

Non-Contributory Family History

Has any member of your family been diagnosed with any of the following conditions (include deceased family members)? Place an "X" under the correct family member with the condition, and indicate if the family member passed away due to that condition.

	Father	Mother	Siblings	Children	Grandparents
Acne	_____	_____	_____	_____	_____
Alopecia	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____
Diabetes Mellitus	_____	_____	_____	_____	_____
Eczema	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Melanoma	_____	_____	_____	_____	_____
Non-melanoma Skin Can.	_____	_____	_____	_____	_____
Psoriasis	_____	_____	_____	_____	_____
Rosacea	_____	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____	_____

List any other important family medical condition(s) you are aware of (do not include common colds or flu). Include date of initial diagnosis if possible.

Family Member *Medical Condition/Date of Initial Diagnosis*

_____

_____

_____

_____

SOCIAL HISTORY:

Current Employment

Are you currently employed? Yes No

Occupation: _____

Occupational History

Exposure to health hazards/ chemicals? Yes No

How would you rate your stress level at work or school? *None* *Low* *Medium* *High*

Marital Status and/or Living Arrangements

Marital Status: *Single* *Married* *Divorced* *Widowed* *Separated*

Do you have any pets? Yes No If yes, what kind: _____

Level of Education

Highest level of education _____

Sexual History

Currently sexually active? Yes No

Use of Drugs, Alcohol or Tobacco

Weekly alcohol consumption	0	1-3	4-7	>7
Weekly tobacco consumption (Packs)	0	1-3	4-7	>7

Do you smoke marijuana? Yes No

Do you use illicit drugs? Yes No

Diet History

Do you have a healthy diet? Yes No

Sleep History / Mental Health History

Sleep 6+ hours a night? Yes No

Social Factors

Do you exercise regularly? Yes No

Do you wear a seat belt? Yes No

REVIEW OF SYSTEMS:

Please place a checkmark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don't understand something please place a "?" by it. Your doctor will discuss any positive responses with you.

Skin:
- ☐ Acne
- ☐ Bruising
- ☐ Dryness
- ☐ Eczema
- ☐ Excessive Sweating
- ☐ Hair Loss
- ☐ Hives
- ☐ Itching
- ☐ New Lesions
- ☐ Psoriasis
- ☐ Rash
- ☐ Skin Color Changes
- ☐ Growths

General:
- ☐ Recent Weight Change
- ☐ Changes in appetite
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Headaches

HEENT:
- ☐ Blurred vision
- ☐ Redness of eyes
- ☐ Itchy/dry eyes
- ☐ Seasonal Allergies
- ☐ Ear Pain
- ☐ Chronic Sinus Problem
- ☐ Mouth Sores
- ☐ Sore Throat

Cardiovascular:
- ☐ High Blood Pressure
- ☐ Heart Trouble
- ☐ Chest Pain
- ☐ Arrhythmia
- ☐ Palpitations
- ☐ Swelling/Leg Pain
- ☐ Pacemaker or Defibrillator

Respiratory:
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Cough

Genitourinary:
- ☐ Frequent urination
- ☐ Burning or Painful urination
- ☐ Incontinence
- ☐ Blood in urine
- ☐ Skin Rashes

Musculoskeletal
- ☐ Joint Pain
- ☐ Joint Stiffness or swelling
- ☐ Numbness or tingling
- ☐ Cold extremities

Endocrine/Glands:
- ☐ Hormone problem or glandular
- ☐ Diabetes
- ☐ Thyroid disease

Neurologic:
- ☐ Frequent or recurring headaches
- ☐ Light headedness or dizziness
- ☐ Fainting
- ☐ Convulsions or Seizures
- ☐ Numbness or Tingling

Hematologic/Lymphatic:
- ☐ Anemia
- ☐ Bleeding or bruising tendency
- ☐ Night sweats
- ☐ Enlarged glands

Allergic/Immunologic:
- ☐ Latex
- ☐ Previous diagnosis of allergic skin diseases
- ☐ Penicillin or other antibiotics
- ☐ Morphine, Demerol or other narcotics
- ☐ Novocain or other anesthetics

Mitchell J. Mandel, M.D., P.C. 116 East 68th Street 1C New York NY 10065

Mitchell J. Mandel, M.D., P.C./Kate M. Klarberg makes efforts to respect patient's need for privacy and individual dignity. We treat patient's protected health information (PHI) as confidential, and we use and disclose PHI only in conformance with state and federal laws. We respect patient's rights over their own PHI. Mitchell J. Mandel, M.D., P.C./Kate M. Klarberg PA-C uses patient's PHI for treatment, payment and healthcare operations. For these purposes, this practice may share patient's PHI with Healthcare providers, health plans, healthcare clearinghouses, and business associates.

Example of use of PHI for treatment: using the results of lab tests for diagnosis.
Example of use of PHI for payment: checking with an insurance carrier to make sure the patient is eligible for benefits.
Example of use of PHI for healthcare operations: to evaluate the quality of care the patient receives.

Mitchell J. Mandel, M.D., P.C./Kate M. Klarberg PA-C does not make certain disclosures of patient's PHI without the patient's authorization. Our practice and its physicians and staff will not use of disclose PHI without the patient's authorization for disclosure to such outside entities as employers, insurance companies, drug companies and journalists, and will not use PHI without authorization for marketing, research or fundraising, except under certain limited circumstances. We will adhere to restrictions on PHI use that the patient has requested and the practice has approved. Mitchell J. Mandel, M.D., P.C./Kate M. Klarberg PA-C requires compliance with these policies.

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize Dr. Mandel/Kate PA-C to apply for benefits on my behalf for covered services rendered by him or his order. I request payment from my insurance company be made directly to Dr. Mandel/Kate Klarberg PA-C. I certify that the information I have reported with regard to my insurance coverage is correct. I understand I am responsible for any deductibles or co-insurance applicable. I understand that some procedures may not be covered by my insurance company and that I am responsible for those charges. I understand that if my insurance company changes, it is my responsibility to notify Dr. Mandel/ Kate Klarberg PA-C. I understand that if my insurance company requires a referral, it is my responsibility to make sure a valid referral is on file with Dr. Mandel/ Kate Klarberg PA-C

I understand that if I am on Medicaid or a Medicaid HMO or any other Medicaid insurance plan, that Dr. Mandel and Kate KlarbergPA-C do not accept any type of Medicaid insurance and that I agree to pay for services rendered as a private pay patient.

I understand I am being seen as a private pay patient and this is voluntary on my part. I understand I have the option of going to a clinic or facility that will accept my Medicaid plan and I choose not to do so.
I understand that some procedures may not be covered by Medicare and that in the event that Medicare does not cover the charges, I will be responsible for those charges and I agree to pay them.

Patient Last Name_____First Name_____MI_____

Signature of patient2 or legal guardian_____Date_____

Print name of patient or legal guardian_____

Insured's Name_____DOB_____

Spouse Child Parent Other_____