MANDEL DERMATOLOGY
NEW PATIENT INTAKE FORMS

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**	**Age:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Address ***(Street, Apt):***	Address ***(City, State, Zip):***	
Cell Phone #:		
Previous or referring doctor:	**Date of last physical exam:**	

PATIENT PORTAL REGISTRATION

Email Address:	I understand that by providing my email address I consent to allowing Mandel Dermatology to send me occasional emails such as appointment reminders.
Desired Portal Username:	**Desired Portal Password:**

DEMOGRAPHIC INFORMATION

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
Preferred Language:	☐ English ☐ Spanish ☐ Other _____
Local Pharmacy:	**Mail Order or Specialty Pharmacy:**

TODAY'S VISIT

Reason for Today's Visit:	
Timing (When did it start?):	**How long have you experienced the symptoms?**
How Frequently Do The Symptoms Occur?:	
Do You Have Any Other Symptom(s)?:	
Do You Experience Any Other Symptom(s):	
Does Anything Make the Symptom(s) Better or Worse?:	
Are Symptom(s) Better or Worse During Any Season(s)?	

PERSONAL HEALTH HISTORY

Height:	**Weight:**

Allergies to medications

☐ *NO KNOWN ALLERGIES* ☐ Acetaminophen ☐ Aspirin ☐ Codeine ☐ Epinephrine (sensitivity) ☐ Erythromycin
☐ Ibuprofen ☐ Latex ☐ Lidocaine ☐ Metal ☐ Sulfur ☐ Tetracycline ☐ Shellfish
☐ **Other (list below)**

Name the Drug	Reaction You Had

Current medications

☐ *NONE* ☐ Retin-A ☐ Clindamycin ☐ Erythromycin ☐ Minocycline ☐ Triamcinolone ☐ Desonide
☐ Doxycycline ☐ Dovonex ☐ Clobetasol
☐ **Other (list below)**

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers that you currently are taking

Name the Drug	Strength	Frequency Taken

PAST MEDICAL HISTORY

Medical History

☐ *NONE* ☐ Anemia ☐ Arthritis ☐ Diabetes ☐ Digestive Disorder ☐ Heart Disease ☐ Hepatitis
☐ High Blood Pressure ☐ High Cholesterol ☐ HIV ☐ Hives ☐ Hormone Deficiency ☐ Kidney Disease
☐ Liver Disease ☐ Low Blood Pressure ☐ Seizures ☐ Skin Cancer ☐ Skin Rash ☐ Sun Burn
☐ Thyroid Disease ☐ Vasovagal Episode (fainting) ☐ HIV ☐ Hives ☐ **Other (list below)**

Condition	Date Diagnosed or Age

Past Surgical History

Year	Surgery Name or Details	Doctor & Hospital

Other hospitalizations

Year	Reason	Hospital

Pregnancy Status		
☐ Pregnant ☐ Not Pregnant ☐ Planning Pregnancy (when) _____		
Birth Control Medication(s)		
Do you use birth control? ☐ Yes (List Below) ☐ No		
Name		Taken Since

How Would You Rate Your Sun Exposure History? ☐ Light ☐ Moderate ☐ Excessive	
Have You Had Any of the Following? ☐ Sun Burns ☐ Blistering Sun Burns ☐ Skin Cancer(s) (Type): _____	

PERSONAL HEALTH & HABITS

Employment & Education	☐ Not Currently Employed ☐ Currently Employed				
	Occupation: _____ Highest Level of Education: _____				
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 & Living	☐ Single	☐ Married	☐ Divorced	☐ Widowed	☐ Separated
	Do you have any pets? ☐ Yes ☐ No				
	Type of Pets: _____				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – packs/day _____	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs? Name of drug(s): _____			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Sex	Are you sexually active?			☐ Yes	☐ No
Exercise, Diet & Other	Do exercise regularly? How often: _____			☐ Yes	☐ No
	Do you have a healthy diet?			☐ Yes	☐ No
	Do you sleep 6+ hours per night?			☐ Yes	☐ No
	Do you wear a seat belt?			☐ Yes	☐ No

MORE ON NEXT PAGES

FAMILY HEALTH HISTORY

HAS ANY MEMBER OF YOUR FAMILY BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS? PLEASE INCLUDE DECEASED FAMILY MEMBERS IN YOUR ASSESSMENT. INDICATE WITH AN X OR CHECK MARK.

	FATHER	MOTHER	SIBLINGS	CHILDREN	GRANDPARENTS
ACNE					
ALOPECIA					
ASTHMA					
DIABETES MELLITUS					
ECZEMA					
HEART DISEASE					
HIGH BLOOD PRESSURE					
MELANOMA					
NON-MELANOMA SKIN CANCER					
PSORIASIS					
ROSACEA					
THYROID DISEASE					

Other Family History	
Condition	Family Member Relation

MORE ON NEXT PAGES

REVIEW OF SYSTEMS

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS OR PROBLEMS? INDICATE WITH AN X OR CHECK MARK. IF YOU ARE UNSURE OR HAVE QUESTIONS ABOUT ANY OF THE BELOW ITEMS, PLACE A? IN THE APPROPRIATE BOX.

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

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

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

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

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

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

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

In addition to providing medical dermatology services, Dr. Mandel, PA Hayley, and our licensed estheticians also specialize in aesthetic and cosmetic dermatology and skin care. Please help us meet your overall goals by answering this brief questionnaire.

These are my areas of concern:

These are my areas of concern: *(Please check any that apply)*

- ☐ Fine lines and wrinkles
- ☐ Deep lines or furrows
- ☐ Areas of excess fat under chin, around love handles, abdomen, bra top, hips, thighs or above knees
- ☐ Laxity of skin on face, eyelids, arms, neck, abdomen, thighs, or breasts
- ☐ Hand rejuvenation (brown spots, thin skin, loss of volume, prominent veins)
- ☐ Surgical, traumatic or acne scars
- ☐ Tired looking skin or skin discoloration
- ☐ Unwanted hair
- ☐ Hair loss
- ☐ Cellulite
- ☐ Dark circles or puffiness around eyes
- ☐ Prominent blood vessels on face or legs

☐ **NONE OF THE ABOVE CONCERN OR INTEREST ME**

I may be interested in the following treatments: *(Please check all that apply)*

- ☐ Botox/Fillers
- ☐ Facials
- ☐ HydraFacials
- ☐ Kybella for fat under chin or on neck
- ☐ PRP for Hair loss
- ☐ Microneedling w/ PRP for aging skin or brown spots
- ☐ Laser Hair Removal
- ☐ Skin Tightening around eyes and mouth
- ☐ BodyFX RF Body Fat Reduction and Body Contouring
- ☐ Isolaz for acne
- ☐ Chemical Peels
- ☐ Microdermabrasion for skin tone and brown spots
- ☐ Laser for brown or red spots
- ☐ Laser resurfacing
- ☐ Other_____

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Mitchell J. Mandel, M.D., P.C./Hayley N. Permut PA-C 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./Hayley N. Permut PA-C uses patient's PHI for treatment, payment and healthcare operations. For these purposes, this pracCtice 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./Hayley N. Permut 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./Hayley N. Permut 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/Hayley N. Permut 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/Hayley N. Permut 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/ Hayley N. Permut 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/ Hayley N. Permut PA-C

I understand that if I am on Medicaid or a Medicaid HMO or any other Medicaid insurance plan, that Dr. Mandel and Hayley N. Permut PA-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 patient or legal guardian_____Date_____

Print name of patient or legal guardian_____

Insured's Name_____DOB_____

Spouse Child Parent Other_____