GERVAISE GERSTNER, M.D.
Dermatology

Welcome To My Office!

1. Your appointment time is reserved for you. If you must reschedule an appointment, please try to do so in a timely fashion so that another patient may be accommodated and you can be rescheduled promptly. Appointments cancelled within less than 24 hours or "no shows" will incur the full office visit fee for the time reserved.
   _____ (Please initial)

2. We will call or email you to confirm your appointment within the week prior to your appointment. Please provide us with your best contact number(s) and/or email on the patient information sheet.
   _____ (Please initial)

3. Telephone calls from patients and their parents (if under 18) are welcome during office hours. Every effort will be made to return calls promptly. If a call is for an illness or an emergency, please inform the office staff at the time of your call.
   _____ (Please initial)

Please do not hesitate to ask any questions pertaining to office procedures or other concerns you may have. We value communication and an open, trusting relationship with our patients.

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Name_____
First Middle Initial Last

Date of Birth __/__/____ ***Age***___ **Sex** M ____ F ___

S.S # _____ ***Marital Status*** single___ married___ divorced___ widowed ___

Address_____
Street address Apt #

_____
City State Zip

Please only list the number(s) that you would like us to contact you at:

Home (___) ____- _____ ***Work*** (___) ____ - _____ **Cell**(___) ____- _____

Email (for confirmation of appts only) _____

_____ (_____)_____
Pharmacy Name **Phone**

May we discuss your medical condition with another family member? Y ___N ___
If yes, whom _____Relationship _____

How were you referred to our practice? _____

In case ofemergency_____Home/Work#_____
Relationship to patient _____ Cell#_____

If patient is a minor (under 18) please enter responsible party information.

Name _____SS# _____ DOB____/____/_____
First Last
Address _____
Street address Apt #

Home (____) _____-_____ Work (___) _____-_____ Cell (___) _____-_____

Patient/Parent's Signature _____Date._____

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PATIENT FINANCIAL POLICY

This practice is fee for service only; complete payment for all services is required at the time of service. Currently, the practice does not accept any insurance plans including Medicare. We accept Cash, Checks, Master Card, Visa, American Express and Discover for your convenience in paying.

At the end of each visit, you will receive a personal itemized receipt along with an insurance receipt for any insurance covered services only after payment is received. Please be sure to call your insurance company ahead of time to discuss your out of network benefits as every insurance plan differs.

If at any time you have any questions about the cost of a procedure proposed by Dr. Gervaise Gerstner, we will be happy to discuss the cost with you. I certify that I have read and understand the financial policy and of Gervaise Gerstner, M.D., and agree to abide by the policy and patient responsibilities.

Signature_____Date._____

Dermatology Medical History

Patient _____Date _____
Reason for today's visit
_____
Please list all current medications (including creams/lotions/ointments, over the counter meds, vitamins, and herbals)
1 _____ 2 _____ 3_____
4_____ 5 _____6 _____
Have you ever had dental anesthesia (Novocain)? No _ Yes _
Any bad reaction? No _ Yes _
Are you allergic to any medications? No __ Yes __ If yes, please list below:
1 _____ 2 _____ 3 _____
Are you allergic to any medications? No __ Yes __ If yes, please list below:
1 _____ 2 _____ 3 _____
4_____5_____ 6 _____
Are you up-to-date on all immunizations? No ___ Yes ___
Do you have now, or have you ever had diseases or conditions of:

Lungs:
Bronchitis Y___ N ___
Emphysema Y___ N ___
Asthma Y___ N ___
chronic Cough Y___N___
Morning Cough Y___N___
Shortness of breath Y___N___
Wheezing Y___ N___

Cardiovascular:
High Blood Pressure Y___N___
Chest Pain Y___ N___
Heart Attack Y___ N___
Heart Murmur Y___N___
Irregular Heartbeat Y___N___
Phlebitis Y___N
Inflammation of vein Y___N___
Blood Clots Y___N___
Pacemaker Y___N___

Other Systemic:
Diabetes Y___ N___
Thyroid Y___N___
Kidney Y___N___
On Dialysis Y___N___
Bladder Y___N___
Gastrointestinal Y___N___
Nausea/vomiting/diarrhea
when taking antibiotics Y___N___
Yeast Infection when
taking antibiotics Y___ N___
Arthritis/Joint Deformity Y___N___

Other Systemic:
Arthralgia Y___N___
Limited motion Y___N___
Artificial Joint (s)Y___N___
Convulsions, Epilepsy or
seizures Y___N___
Fainting Y___N___
Herpes/Cold Sores Y___N___
HIV Y___N___
AIDS Y___N___
Hepatitis Y___N___

Please list any other medical conditions or diseases:

Please list any surgical procedures:

_____
Type of Surgery Date

_____
Type of Surgery Date

Skin:

Have you ever had skin cancer? Yes___ No___

If yes, where _____ Type of Skin cancer _____

Has anyone in your family had skin cancer? Yes___ No___

If yes, whom _____ Type of skin cancer _____

Do you have a history of any specific skin diseases? Yes__ No__
Do you have problems with healing? Yes__ No__
Do you develop keloids (scars) after surgery? Yes__ No__
Do you bleed easily? Yes__ No__

Do you have any tattoos or permanent makeup? Yes__ No__
Do you develop skin rashes in reaction to:
Medications __ Food__ Environment __ Bandages __ Topical Neosporin __
Other _____

Social History:
Do you drink alcohol? Yes__ No__ If yes_____ drinks per week
Do you use IV drugs? Yes __ No__ If yes, what? _____ How often? _____
Do you smoke? Yes __ No __ If yes, how much _____
What is your occupation? _____

For women only:
Do you have irregular periods? Yes__ No__ Are you pregnant? Yes___ No___
Are you breast- feeding? Yes__ No__ Completed by: Patient ___ MA____ (initials)

Signed by Patient _____Date _____

Reviewed by _____Date_____

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Cosmetic Interest Questionnaire

Patient: _____ Date: _____
Health issues and procedures or products of interest to you
(check all that apply)

__ Acne
__ Acne Scar Reduction
__ Birthmarks
__ Botox® Cosmetic
__ Chemical Peels
__ Excessive Sweating
__ Eyelashes: Longer, Thicker, Darker or Extensions
__ Facial Rejuvenation
__ Frown lines between the brows
__ Hair Removal
__ Laser Treatments
__ Lines around nose and mouth
__ Liver Spots/ Age Spots
__ Make-up: Applications or Lessons
__ Skin Tightening
__ Microdermabrasion
__ Mole or Scar Removal
__ Red Spots/Rosacea
__ Removing Facial Vessels
__ Sunscreen Advice
__ Juvederm® or Other Fillers
__ Scar Reduction
__ Skin Care Advice
__ Skin Care Products
__ Spider Vein Treatment
__ Fat Reduction (Contouring)
__ Wrinkle Reduction/Therapy
__ Nutrition and Exercise consulting

Other, please specify:

_____