Surgical & Cosmetic Dermatology of Rhode Island

Phone: 401-751-7546--Fax: 401-751-6888
Email: info@RhodeIslandMohs.com
www.RhodeIslandMohs.com

□Please return the attached information (2 pages) to the address, fax or email address listed
□Please call our office if you are a previous patient of Dr. Kuperman-Beade.
□No perfume is to be worn in the office by patients or anyone that comes with a patient.

Referrals

It is your responsibility to get a referral faxed to our office from your PCP (Prior to your appointment) if you have the following insurances:

□ BCBS HMO (example your insurance ID is MTN or MTP), BCBS EPO, any other BCBS plan that requires a referral
□ Blue Chip for Medicare
□ United Healthcare Medicare Complete, United Healthcare Medicare Solutions or AARP Medicare Complete HMO
□ US Family
□ Any other HMO

YOU MUST BRING YOUR INSURANCE CARD(S) AND A PICTURE ID TO YOUR APPOINTMENT.

Name: _____ Date of Birth: _____

Patient Home Phone**:** _____ Patient Cell Phone: _____

Patient Work Phone: _____ext_____

Which # can we leave detailed messages at? □ Home □Cell □Work

Email address: _____

Primary care Physician:_____ Cardiologist: _____

Local Pharmacy Information

Name of Pharmacy: _____ Pharmacy Phone Number:_____

Pharmacy Street Name: _____ Pharmacy City:_____

Alternate individual(s) to release my Medical information to (ex. Family or Friend):

Name_____Relationship_____Phone:_____

If the above individual calls the office they will be able to receive my medical information.

Please read and sign below

Financial Consent

Surgical and Cosmetic Dermatology of Rhode Island has permission to bill my Insurance Company (s) for fees associated with my treatment. I will be responsible to pay my deductible, co-pay(s) or co-insurance. I understand it is my responsibility to get a referral from my Primary Care Physician if I have an HMO.

Patient Signature: _____ Date: _____/_____/_____

Photography Consent

I consent for medical photographs to be made of me (or person for whom I am the Power of Attorney for). I understand that the information may be used in my medical record.

Patient Signature: _____ Date: _____/_____/_____

Pharmacy History Consent

I consent for my Pharmaceutical history to be obtained if necessary. This will insure I am not prescribed any duplicate or similar prescriptions.

Patient Signature: _____ Date: _____/_____/_____

Privacy Practices Acknowledgement

A copy of the Notice of Privacy Practices is available at the check-in counter. You can also call and request one be sent to you.

I have been offered the Notice of Privacy Practices and I have been provided an opportunity to review it. I understand that a copy of the Notice of Privacy Practices is posted in the office lobby and I may request a copy.

Patient Signature: _____ Date: _____/_____/_____

Electronic Communication

I agree to the use of electronic communication, including Email and Text. With regards to communication with Dr. Kuperman-Beade and her staff, I understand and agree with the AMA Guidelines (H-478.997) as outlined in the hand out available at the office.

Patient Signature: _____ Date: _____/_____/_____

Surgery is not done on the day of your consultation.

Name: _____ D.O.B. _____

REVIEW OF SYMPTOMS

Overall, how do you feel physically? □Excellent □Good □Fair

Heart □Angina □Defibrillator □Pacemaker □Heart Failure □Stents □Heart Murmur
□Heart Attack(s) □High Blood Pressure □other _____

Psychiatric □Anxiety □Depression □Frequent fainting spells □other _____

Muscular/Skeletal □Arthritis □Hip replacement □Knee replacement

Pulmonary □Emphysema □Asthma □Shortness of breath □Chronic cough □Other _____

Hematologic □Bleeding problems □Anemia □Bruises easily □Other _____

Cancer □Breast □Lung □Lymphoma □Other _____

Healing Problems □Keloids □Skin discolorations □Other _____

Infectious Disease □High risk for AIDS □Hepatitis □Tuberculosis □HIV+ □Other

Genitourinary □Prostate issues □Transplant □Kidney disease □Dialysis □Other

Liver □Liver disease □Cirrhosis □Hepatitis

Gastrointestinal □Irritable bowel □Ulcers □Reflux □Other _____

Neurological □Seizures □Stroke(s) □TIA □Frequent headaches □Migraines

Endocrine □Thyroid disease □Diabetes □Other_____

Eyes □Decreased vision □Eye pain □Glaucoma □Constant tearing

Ears □Decreased hearing □Hearing aides

Nose □Draining allergies □Restricted breathing

Surgical History: _____

Any other Past Medical History: _____

Allergies Are you allergic to any medications? □No □Yes _____

Do you need to take antibiotics prior to dental work? □No □Yes, reason _____

Medications: Do you take: □Aspirin _____mg's daily □Coumadin/Warfarin □Plavix □Pradaxa □Xarelto

Please list any other medications/supplements/vitamins that you are currently taking:

_____

_____

Social History Do you smoke? □Never □Former □Yes packs per day=_____
Do you drink alcohol □No □Yes if yes, Frequency □Daily □Weekend □Social occasions

Family History Has any genetic family member had skin cancer? □No □Unknown
□Yes: Relationship_____ □Alive/age_____ □Deceased

Chief Complaint □Skin cancer □Other issue _____

History of present illness

What are the symptoms? □none □Bleeding □Itching □Scabbing □Pain if yes, please rate it 0-10 ___ (0=no pain/10=worst possible pain)

Has it previously been treated with: □none □Cryotherapy (liquid Nitrogen) □Burned/Scraped □Radiation

Dermatologic History

Have you had skin cancer before? □no □yes

FOR STAFF USE ONLY BP: _____/_____ Pain Scale _____ (0-10)

Location: _____

DX: _____

Size: _____x _____ cm

Description: _____

Closure _____
Staff check list:___summary ___edu ___RID List ___ Plas. Ref ___Plas. Act ____Rad. Ref ___Slides request ____Prog.Note