Peter A. Vitulli, Jr., D.O., F.A.O.C.D., F.A.A.D.
Board Certified Dermatologist I Board Certified Mohs Surgeon
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The information you provide below is confidential and for our records.
Please, print. A larger printed version is also available upon request.

Today's Date: ______________________

Patient's Name: Last_______________________________ First___________________________
Street Address: ____
City: _______________________________ State: _______________ Zip:___________________
Phone number: Cell______________________________ Work____________________________
Date of birth: _____/_____/_____ Sex: M F Marital Status: M W S D
If married, spouses' name: ____
Race: _________________ Ethnicity: ________________ Language spoken:________________
Employer: ________________________________ Occupation:_____________________________
Do you work indoors/outdoors?_____________
Social Security#: ________/________/_________
Email address: ____
Primary Care Physician: ____________________________________ Phone: ________________
If minor, name of parent or guardian: ____

Insurance Information
Primary insurance: _______________________________
ID#: _______________________________________ Group #: _____________________________
Policy holder: ____
Relationship:___________________________________DOB: _____/_____/_____
Secondary insurance: ____________________________
ID#: _______________________________________ Group #: _____________________________
Policy holder: ____
Relationship:___________________________________DOB: _____/_____/_____

Emergency contact name: __________________________________ Phone: _________________

How did you hear about us?: ____ or
Whom may we thank for your referral to our office?: _____________________________________

Assignment of Benefits

Please, initial each line item and sign below.

Initial:_______ **Records Release**: I authorize the release of my health information by the Practice for the purposes of my current treatment, including release of information to my referring or primary care provider and other health care providers participating in my current treatment, or as otherwise necessary for the Practice to provide treatment to me. I authorize the release of medical information (including billing information) as necessary for payment purposes to my insurance company, and any other person or entity responsible for payment for my medical treatment. I authorize the release of my health information to business associates of the Practice as necessary for the purposes of the Practice's health care operations.

Initial:_______ **Assignment of Benefits**: I authorize payments of medical benefits to the Practice and its providers for services rendered to myself and/or my dependents.

FOR MEDICARE RECEPIENTS ONLY:

Initial:_______ **Medicare Authorization**: I request that payments of authorized Medicare benefits be made on my behalf to the Practice for any services furnished to me by its providers. I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Initial:_______ **MEDIGAP**: I request that payments of authorized MEDIGAP benefits be made on my behalf to the Practice for any services furnished to me by its providers. I authorize any holder of my medical information to release to the MEDIGAP carriers any information needed to determine these benefits payable for related services. I understand I may refuse to sign this authorization and realize this may result in a delay of treatment and/or have potential adverse health consequences. I understand I may change or revoke this authorization at any time.

I certify that I have read and fully understand the procedural office policies of the Practice, including its Financial policy, and I agree to be bound by their terms.

_____________________________ _________________________

Patient's Name (please, print) Patient's Date of Birth

_____________________________ _________________________

Patient/Responsible Party Signature Date

Privacy Protection

The Health Insurance Portability and Accountability Act (HIPAA) requires **A Center For Dermatology, Cosmetic and Laser Surgery** (Practice) to obtain your authorization to allow communications regarding your protected health information. This authorization gives permission to our staff to discuss your health care with a family member or any other individual that you may designate. It also allows us to leave recorded messages at your home, work, or on your cell phone related to your medical care and treatment, payment, appointment status, or follow-up. Please, list phone number(s) in order of preference for receiving appointment reminder and/or patient care calls:

Please, circle type: *Please, circle messaging preferences below:*

1. Home / Cell / Work ____________________no message / message to call / detailed message
2. Home / Cell / Work ____________________ no message / message to call / detailed message
3. Other __________________________ no message / message to call / detailed message

Please, check an applicable option below:

☐ I give permission to the Practice to contact me via e-mail with news announcements, events, and promotions.

Email:____

☐ I choose to opt out of e-mail announcements.

This authorization allows A Center For Dermatology, Cosmetic and Laser Surgery to discuss all aspects of my protected health information with the individuals listed below:

Name:_________________________Relationship:________________Phone:_______________

Name:________________________Relationship:_______________Phone:_________________

The Notice of Privacy Practices is available for your review at the office. Please, ask our staff if you wish to obtain a copy for your records.

____ ______________________

Patient's Name (please, print) Patient's Date of Birth

____ _______________________

Patient/Responsible Party Signature Date

PLEASE, COMPLETE FOR THE MEDICAL STAFF USE

Patient Name: (please print) ____
Date of Birth: _____/_____/_____ Age: _____________

Who is your Primary Care Physician: ________________________ Ph#: __________________________
Whom may we thank for your referral to our office?: ____
Pharmacy of your choice: (please, provide address and phone)
____
____

Do you have any medical conditions that have required treatment? If so, please explain:
____
____
____

Have you ever had surgeries or have been hospitalized? If so, please list reason and dates below:
____
____
____

Please, list all current medications and dosages:
____
____
____
____
____

Please, list all allergies and what reactions these allergies cause:
____
____
____
____
____

When were you last vaccinated for:
Tetanus _______________ Flu _______________ Pneumonia_______________

Advance directive: a legal document, also called a living will, that advises your family and healthcare professionals of your decisions regarding your medical care, should you become incapacitated and unable to make decisions on your own.
Have you prepared a living will? (please, circle one) **Yes** **No**

Skin Disease History: (please, check all that apply)

Melanoma
Precancerous Moles/Dysplastic Nevi
Basal Cell Skin Cancer
Squamous Cell Skin Cancer
Actinic Keratoses
Blistering Sunburns
Psoriasis
Hay Fever / Allergies
NONE
Other_____________________

Acne
Dry Skin
Flaking or Itchy Scalp
Poison Ivy
Eczema
Cold Sore
Herpes (circle that apply) Oral or Genital
Auto Immune Disorder

Do you wear sunscreen? **Yes** **No** If yes, what SPF? _________ Do you reapply? _______
Do you tan in a tanning bed? **Yes** **No**
Do you have a family history of melanoma? **Yes** **No**
If yes, which relative(s)? ____
Any other relevant family history? ____

Social History: please, circle all that apply

Cigarette Smoking: Never Quit: former smoker Smoke less than daily Smoke daily
Do you drink alcohol? Yes No Do you use recreational drugs? Yes No
If so, what and how often ____

How often do you exercise?	Several times a day	Once a day	A few times per week	A few times per month	Never
What is your caffeine use?	Several times a day	Once a day	A few times per week	A few times per month	Never

Sexual History:

- Not sexually active
- Active with one partner
- Active with more than one partner
- Same sex partner

Medical/ Disease History: please circle/ indicate Yes or No

Allergy to Lidocaine	Yes	No
Allergy to Epinephrine	Yes	No
Rapid Heart Beat w/ Epinephrine	Yes	No
Allergy to Latex	Yes	No
Allergy to Adhesive	Yes	No
Allergy to Topical Antibiotic	Yes	No
Premedication prior to procedures	Yes	No
Artificial Joints with past 2 years	Yes	No
Blood Thinners	Yes	No
Defibrillator	Yes	No
Pacemaker	Yes	No
Artificial Heart Valve	Yes	No
Pregnancy or planning a pregnancy	Yes	No
Problems with scarring (hypertrophic or Keloid)	Yes	No
Problems with healing	Yes	No
Problems with bleeding	Yes	No
MRSA	Yes	No
Joint aches	Yes	No
Seizures	Yes	No
Immunosuppression	Yes	No
Anxiety	Yes	No
Depression	Yes	No
Rash	Yes	No
Chest pain	Yes	No
Fever or chills	Yes	No
Night sweats	Yes	No
Sore throat	Yes	No
Blurry vision	Yes	No
Abdominal pain	Yes	No
Muscle weakness	Yes	No
Neck stiffness	Yes	No
Headaches	Yes	No
Cough	Yes	No
Shortness of breath	Yes	No
Wheezing	Yes	No

First Degree Family History: (please circle all that apply)

Melanoma:	Mother	Father	Sister	Brother	Daughter	Son	N/A
Cancer:	Mother	Father	Sister	Brother	Daughter	Son	N/A
Psoriasis:	Mother	Father	Sister	Brother	Daughter	Son	N/A
Arthritis:	Mother	Father	Sister	Brother	Daughter	Son	N/A
Diabetes:	Mother	Father	Sister	Brother	Daughter	Son	N/A
Colitis:	Mother	Father	Sister	Brother	Daughter	Son	N/A
Atrial Fibrillation:	Mother	Father	Sister	Brother	Daughter	Son	N/A
Hypertension:	Mother	Father	Sister	Brother	Daughter	Son	N/A
Heart Disease:	Mother	Father	Sister	Brother	Daughter	Son	N/A
Bleeding Disorders:	Mother	Father	Sister	Brother	Daughter	Son	N/A
Liver Disease:	Mother	Father	Sister	Brother	Daughter	Son	N/A
Kidney Disease:	Mother	Father	Sister	Brother	Daughter	Son	N/A
Genetic Disorders:	Mother	Father	Sister	Brother	Daughter	Son	N/A
Seizure Disorder:	Mother	Father	Sister	Brother	Daughter	Son	N/A
Stroke:	Mother	Father	Sister	Brother	Daughter	Son	N/A
Anxiety:	Mother	Father	Sister	Brother	Daughter	Son	N/A
Depression:	Mother	Father	Sister	Brother	Daughter	Son	N/A
Smoking:	Mother	Father	Sister	Brother	Daughter	Son	N/A
Alcoholism:	Mother	Father	Sister	Brother	Daughter	Son	N/A
Drug Dependency:	Mother	Father	Sister	Brother	Daughter	Son	N/A

Minor In-Office Treatments and Procedures Consent

Skin biopsies, treatments with liquid nitrogen (cryotherapy) and intralesional injections are some of the most commonly performed procedures during dermatological examinations.

Skin biopsy is a minor surgical procedure which involves removal of a small piece of skin under local anesthesia to obtain diagnostic information.

Cryotherapy is used to treat/remove/destroy numerous benign, precancerous, and cancerous skin conditions. Some of these include warts, sunspots, actinic keratoses, and superficial skin cancers.

Intralesional (and intramuscular) steroid injections are often performed to decrease pain, swelling and inflammation.

These procedures/treatments may be associated with certain side effects and complications, which include, but are not limited to the following:

BIOPSY	CRYOTHERAPY	INJECTION
Bleeding **Pain** **Infection** **Change of pigmentation** **Nerve damage** **Recurrence of growth** **Altered skin sensation** **Scarring**	Pain Infection Redness and erythema Blister and scab formation Discoloration Nerve damage Altered skin sensation Scarring	Bleeding Pain and hypersensitivity Infection Bruising Abscess Discoloration Skin atrophy

Multiple treatments/procedures may be needed to achieve an optimal resolution of concerning issues. Feel free to ask your provider any questions regarding the above procedures and their complications.

Authorization for treatment

I certify that I have read and fully understand the information contained in this document. I accept the risks and complications of the described procedures, and hereby authorize the physicians and clinical staff of the Practice to administer these treatments/procedures as deemed necessary during the course of my visits with Dr. Vitulli. I understand that I will not be executing a new Consent form for minor treatments in the office each time I have one of the procedures outlined above, and that this form, signed by me today, will serve as consent for future visits as well, for those procedures. I will not hold Dr. Vitulli, his associates and staff members of the Practice liable for any adverse side effects associated with these procedures.

__________________________________ ____________________

Patient’s Name (please, print) Patient’s Date of Birth

________________________________ _____________________

Patient/Responsible Party Signature Date

Cosmetic Questionnaire

Patient's Name: ______________________________________ Date: ______________

Areas of concern: (please, check all that apply)

- ☐ Sun damaged skin
- ☐ Brown spots, age spots, uneven skin tone
- ☐ Melasma
- ☐ Acne, acne scarring
- ☐ Rosacea, (facial redness), facial veins
- ☐ Skin laxity or loss of elasticity
- ☐ Fine lines and wrinkles
- ☐ Deep lines or wrinkles
- ☐ Excess body fat
- ☐ Tattoo removal
- ☐ Excessive sweating
- ☐ Leg veins
- ☐ Excessive hair growth, hair removal
- ☐ Surgical scars

Would you like information on any of the following procedures? (please, check all that apply)

- ☐ Botox® or Dysport® to decrease the appearance of fine lines and wrinkles
- ☐ Sculptra® (dermal filler to gradually add volume and improve the appearance of deep facial lines);
- ☐ Juvederm®, Restylane®, Radiesse® or Belotero® family of fillers (dermal fillers to correct mild to moderate facial lines and wrinkles, restore structure and add volume)
- ☐ Laser treatments for overall rejuvenation, and to minimize the appearance of unwanted pigment, improve skin texture and tone, or to reduce redness (CO2, PicoSure®, IPL, Elite Plus);
- ☐ Laser hair removal;
- ☐ Tempsure™ Envi Radio Frequency skin tightening system (face and body);
- ☐ Tempsure™ Vitalia Radio Frequency vaginal rejuvenation and women's wellness system;
- ☐ Body contouring and fat reduction treatments;
- ☐ Psoriasis or vitiligo treatments with Xtrac laser;
- ☐ Skin care products.

Thank you