RAPPAPORT DERMATOLOGY
PATIENT MEDICAL HISTORY(Requires update every 3 years)

Last Name_____First Name_____Middle_____
Date of Birth_____Occupation_____
Address:_____
Home Phone: _____Cell Phone: _____Mobile carrier:_____
Email Address: _____Sex: □M□ F Marital Status_____
Primary Physician:_____Did your primary doctor refer you to us? Y □ N □
Pharmacy:_____Location:_____
Primary reason for appointment(list single problem here)_____
How long have you had this problem?_____Have you received treatment?_____
If so, please
describe_____
Do you have other skin problems you would like evaluated?_____
Do you have any pain with the problem(s) we are seeing you for? Y □ N □
How bad is pain from scale of 0-10(0 being none and 10 being severe) _____
Please list all current medications and dosage: (Attach List if needed)

_____
Please list any allergies_____
Are you allergic or sensitive to: Y □ N □ Novocaine Y □ N □ Lidocaine Y □ N □
Are you allergic to Latex? Y □ N □
Do you take antibiotics for dental procedures? Y □ N □ If yes, please list_____
Are currently on any type of blood thinner: Y □ N □ (i.e. Coumadin, Plavix, Aspirin, etc.)
If yes_____

SURGICAL HISTORY:

Y□ N□ Mohs Surgery Y□ N□Coronary Bypass Y□ N□Artifical Heart Valve
Y□ N□ Artifical joint Y□ N□Implanted Defibrillator Y□ N□Pacemaker
Have you ever had skin surgery? Y□ N□ If yes, type_____
Have you ever had cosmetic surgery? Y□ N□ If yes, type_____
Have you had any other surgery in the past 5 years? Y□ N□ Please describe_____
_____

HAVE YOU HAD ANY OF THE FOLLOWING:

Y□ N□ Actinic Keratosis
Y□ N□ Anemia
Y□ N□ Anxiety/Depression
Y□ N□ Arthritis
Y□ N□ Asthma
Y□ N□ Biopsied Abnormal Moles
Y□ N□ Bipolar Disorder
Y□ N□ Bleed Easily
Y□ N□ Blood Clot
Y□ N□ Diabetes
Y□ N□ Dizziness/Fainting
Y□ N□ Ear Problems
Y□ N□ Eczema
Y□ N□ Exposure to HIV/AIDS
Y□ N□ Eye Problems
Y□ N□ Genetic Disease
Y□ N□ Hair Problems
Y□ N□ Hay Fever
Y□ N□ Headaches
Y□ N□ Heart Attack
Y□ N□ Heart Surgery
Y□ N□ Hepatitis Virus
Y□ N□ High Blood Pressure

Y□ N□ Keloid Scars
Y□ N□ Kidney Trouble
Y□ N□ Liver Disorder
Y□ N□ Lung Disease
Y□ N□ Melanoma
Y□ N□ Mitral Valve Prolapse
Y□ N□ Nervous Disease
Y□ N□ Oral Sores
Y□ N□ Other Cancer _____
Y□ N□ Palpitations
Y□ N□ Problems with healing
Y□ N□ Psoriasis
Y□ N□ Radiation Treatment
Y□ N□ Seizure Disorder
Y□ N□ Sinus Trouble
Y□ N□ Skin Cancer
Y□ N□ Stroke/TIA
Y□ N□ Thyroid Trouble
Y□ N□ Tuberculosis

HEALTH MAINTENANCE
When was your last mammogram?_____(Only answer if applies to you and are over 35 years old)
When was your last flu shot?_____ When was your last Pneumonia Vaccine?_____
If you are 65 or older, do you have an advanced care plan, DNR or surrogate decision maker registered with your primary care physician or hospital. Y□ N□ If yes, list_____
Covid Vaccines Y□ N□ Covid BoosterY□ N□

FAMILY HISTORY:Has anyone in your immediate family had any of the following types of skin cancer or disease?
Y□ N□ Melanoma Y□ N□ Squamous Cell Carcinoma Y□ N□ Basal Cell Carcinoma
Y□ N□ Actinic Keratosis(Precancerous lesions) Y□ N□ Biopsied Abnormal Moles
Other family history of skin disease_____
Is there anything about your medical history which would be useful or important for your physician to know? Please list or remember to discuss with your doctor:_____

SOCIAL HISTORY:
Do you drink alcohol? Y□ N□ Frequency: daily □ Social □Quantity □Occasionally □
Do you use any illicit drugs? Y□ N□ If so, what type?_____
Do you smoke? Y□ N□ If Yes, □Daily □Occasionally Do you live in a smoke-free home?
Y□ N□ Do you consume caffeine? Y□ N□ If yes, Coffee□Soda □Tea □Chocolate □
Do you use sunscreen? Daily__ When outside for any length of time □ Often □Sometimes □Never □
Type of sunscreen: SPF15 □SPF30 □ SPF30 or greater □ . Have you ever had blistering sunburns?
Y□ N□ (Females Only) Are you pregnant or trying to become pregnant? Y□ N□
(Females Only) Are you taking birth control pills? Y□ N□ If yes, please list_____

RAPPAPORT DERMATOLOGY POLICY CONSENTS
I, the undersigned, certify that I (or my dependent) assign directly to Dr. I. Paul Rappaport, all insurance benefits for services rendered. Medicare and/or other insurance carriers will only pay for services that it determines to be "reasonable and necessary." If my insurance company determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under my policy with my insurance carrier, they may deny payment for these services and I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

My signature below shows that I understand that all copays, coinsurance, deductibles, non par insurance and self pay are due at the time of services rendered. I understand that I. Paul Rappaport, M.D. has the right to charge me $35 for all returned checks, $50 no show fee for office appointments and $150 no show fee for procedures if I no show my appointment or fail to give 24 hours notice.

I, the undersigned, give consent to I. Paul Rappaport, M.D. to electronically query and retrieve my medical records for treatment purposes from all available sources. This includes, but is not limited to, demographic information as well as other clinical documentation that may be available through sources such as the Carequality Interoperability Framework, Surescripts, or other connected entities.

I, the undersigned, give consent to to retrieve and use my medication history from SureScripts.

I authorize you to send and/or leave messages for me for portal information, medical information, billing information and appointment information: ☐Voicemail ☐With another person ☐Email ☐Text ☐Mail

My signature below authorizes I. Paul Rappaport, M.D., general consent for evaluation, treatment and the understanding of I. Paul Rappaport, M.D. financial policies.

I, certify that this information is to the best of my knowledge and believe is true, correct and complete and my signature below indicates I authorize all of the above.

_____ _____

Patient or Guardian Signature Date

I give I. Paul Rappaport, M.D. permission to release medical information to the above referring physician.

_____ _____

Patient or Guardian Signature(Sign only if sending records) Date

COSMETIC INFORMATION QUESTIONNAIRE

Would you be interested in learning more about (Check box if interested)

Y☐ N☐ Personalized Skin Care
Y☐ N☐ Botox for facial Frown/Expression Lines
Y☐ N☐ Gentlewaves Skin Fitness
Y☐ N☐ Decreasing Pore Size and Facial Redness
Y☐ N☐ Chemical Peels
Y☐ N☐ Laser Tattoo Removal
Y☐ N☐ Laser Spider Vein Removal
Y☐ N☐ Laser Removal of Wrinkles
Y☐ N☐ Laser Removal of Acne Scars
Y☐ N☐ IPL Photofacials
Y☐ N☐ Vibradermabrasion
Y☐ N☐ Hair Removal
Y☐ N☐ Juvederm(Filler for wrinkles)
Y☐ N☐ Laser Age Spot Removal
Y☐ N☐ Laser Facial Rejuvenation
Y☐ N☐ Sclerotherapy for Leg Veins
Y☐ N☐ Pulsed Light Treatment for Acne