



MONARCH DERMATOLOGY

MEDICAL • SURGICAL • COSMETIC

PRIYA S. THAKKER, MD
DIVYA S. BHATNAGAR, MD

719 N. BEERS ST, SUITE 2G
HOLMDEL, NJ 07733
(732) 739-3223

Today's Date _____ Appointment Date _____

Last Name _____ First Name _____ Middle Initial _____
Birthdate _____ Age _____ Title: (circle one) Mr. Mrs. Dr. Ms. Miss Sex: (circle one) M F
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell _____ Work _____
Email _____ SS# _____

May we leave a detailed voicemail? YES NO Marital Status (circle one) Single Married Separated Divorced Widowed

Occupation _____ How did you hear about us? _____

Primary Care Physician: (LAST) _____ (FIRST) _____ Phone _____

Address _____ City _____ State _____ Zip _____

Referring Physician: (LAST) _____ (FIRST) _____ Phone _____

Address _____ City _____ State _____ Zip _____

IN CASE OF EMERGENCY

Name _____ Relation _____ Phone _____

PLEASE LIST YOUR PHARMACY (For e-prescribing purposes)

Pharmacy Name: _____ Phone _____ Address: _____

May we obtain your prescription history directly from your pharmacy? YES NO

Primary Insurance _____ ID number _____

Subscriber Name _____ Subscriber DOB _____ SS# _____

Patient's relationship to subscriber: (circle one) Self Spouse Child Other

Secondary Insurance _____ ID number _____

Subscriber Name _____ Subscriber DOB _____ SS# _____

Patient's relationship to subscriber (Circle one) Self Spouse Child Other

Please CHECK all that apply:

PAST MEDICAL HISTORY: NONE

- | | | |
|---|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> COPD | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hypercholesterolemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hyperthyroidism (overactive) |
| <input type="checkbox"/> BPH | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Hypothyroidism (underactive) |
| <input type="checkbox"/> Bone Marrow Transplant | <input type="checkbox"/> GERD | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Prostate Cancer | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Stroke | | |

Other Important Medical History _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand I am responsible for any balance. I also authorize Monarch Dermatology or the insurance company to release any information required to process my claims.

Patient or Parent/ Guardian Signature _____ Date _____



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NAME _____

PAST SURGICAL HISTORY: NONE

- | | |
|---|---|
| <input type="checkbox"/> Appendix (Appendectomy) | <input type="checkbox"/> Kidney Biopsy |
| <input type="checkbox"/> Bladder (Cystectomy) | <input type="checkbox"/> Kidney Removed: (Right, Left) |
| <input type="checkbox"/> Breast: Mastectomy (Right, Left, Bilateral) | <input type="checkbox"/> Kidney Stone Removal |
| <input type="checkbox"/> Breast: Lumpectomy (Right, Left, Bilateral) | <input type="checkbox"/> Kidney Transplant |
| <input type="checkbox"/> Breast: Breast Biopsy (Right, Left, Bilateral) | <input type="checkbox"/> Ovaries Removed: Endometriosis |
| <input type="checkbox"/> Breast: Breast Reduction | <input type="checkbox"/> Ovaries Removed: Cancer |
| <input type="checkbox"/> Breast: Breast Implants | <input type="checkbox"/> Ovaries Removed: Cyst |
| <input type="checkbox"/> Colon: Colon Cancer Resection | <input type="checkbox"/> Prostate Removed: Cancer |
| <input type="checkbox"/> Colon: Diverticulitis | <input type="checkbox"/> Prostate Biopsy |
| <input type="checkbox"/> Colon: Inflammatory Bowel Disease | <input type="checkbox"/> Prostate: TURP |
| <input type="checkbox"/> Gallbladder Removed | <input type="checkbox"/> Skin Biopsy |
| <input type="checkbox"/> Heart: Coronary Artery Bypass (CABO) | <input type="checkbox"/> Skin: Basal Cell Carcinoma Surgery |
| <input type="checkbox"/> Heart: PTCA (Angioplasty) | <input type="checkbox"/> Skin: Squamous Cell Carcinoma Surgery |
| <input type="checkbox"/> Heart: Mechanical Valve Replacement | <input type="checkbox"/> Skin: Melanoma Surgery |
| <input type="checkbox"/> Heart: Biological Valve Replacement | <input type="checkbox"/> Spleen Removed |
| <input type="checkbox"/> Heart Transplant | <input type="checkbox"/> Testicles Removed (Right, Left, Bilateral) |
| <input type="checkbox"/> Knee Replacement (Right, Left, Bilateral) | <input type="checkbox"/> Uterus (Hysterectomy): Fibroids |
| <input type="checkbox"/> Hip Replacement (Right, Left, Bilateral) | <input type="checkbox"/> Uterus (Hysterectomy): Uterine Cancer |

Other Important Surgical History: _____

SKIN DISEASE HISTORY: NONE

- | | | | |
|---|--|-------------------------------------|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Blistering sunburns | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Precancerous Moles |
| <input type="checkbox"/> Actinic Keratosis | <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> Poison Ivy | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Squamous Cell Skin Cancer | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Psoriasis |

Other: _____

BCC or SCC: Year _____ Location _____ Treatment _____

Melanoma: Year _____ Location _____ Treatment _____

Do you wear Sunscreen? Yes No What SPF? _____ Have you ever tanned in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No Who? Mother Father Brother Sister

Do you have a family history of Stroke? Yes No Who? Mother Father Brother Sister

ALLERGIES TO MEDICATIONS: (please list drug allergies) NONE

_____	_____
_____	_____
_____	_____

SOCIAL HISTORY:

IV Drug/Drug Use: Yes No	Smoking Use: Never	Alcohol Use: None
	Currently Smokes - daily	less than 1 drink/day
	Currently Smokes - not daily	1-2 drinks/day
	Has smoked in the past	3 or more drinks /day



NAME _____

REVIEW OF SYSTEMS: NONE

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Changing mole | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Cough | <input type="checkbox"/> Neck stiffness |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Depression | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Problems with scarring | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Fever or chills | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Problems with healing | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Problems with bleeding | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Yeast infections w/ antibiotics | <input type="checkbox"/> Bloody stool | <input type="checkbox"/> Immunosuppression | <input type="checkbox"/> Unintended weight loss |
| <input type="checkbox"/> GI upset w/ antibiotics | <input type="checkbox"/> Bloody urine | <input type="checkbox"/> Joint aches | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Pregnancy / planning pregnancy | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Chest pain |

ALERTS: NONE

- Allergy to adhesive
- Allergy to latex
- Allergy to Lidocaine
- Allergy to topical antibiotic ointments
- Artificial heart valve
- Artificial joints in the last two years
- Blood thinners
- Defibrillator
- MRSA
- Pacemaker
- Personal history of atypical moles
- Personal history of dysplastic nevi
- Personal history of Melanoma
- Premedication prior to procedures
- Rapid heartbeat with epinephrine
- Pregnant or planning pregnancy

Who is your Primary Care Physician? _____

Month & Year of Last Visit _____

Did you receive the flu vaccine before this past flu season? Yes No

If not, what was the reason? _____

Do you have a history of melanoma? Yes No

Do you smoke? Yes No

Do you drink 5 or more alcoholic beverages in one day, more than twice a year? Yes No

Do you have an Advance Care Plan? Yes No

If so, what is the name of your Surrogate Decision Maker? _____



CO-PAYMENT AND DEDUCTIBLES

Payment is required for all services at the time they are rendered. Co-payments will be collected at the time of service. I understand that in the event that my services are not covered under my insurance, I accept full financial responsibility of those non-covered services. An administrative billing fee of \$10 will be applied if co-payments are not paid at the time of service. In the event that your account must be turned over for collections, interest and/or a collection fee at the provider's current rate may be charged on all balances owing that are past due. I further acknowledge that I am responsible for the co-insurance and/or deductible under my health plan's agreement and should my account be sent to a collection agency, I shall be responsible for the collection agency fee or the actual collection cost. Your signature below signifies understanding of this policy.

REFERRAL POLICY

If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my primary care provider and assure that it is available at the time of my visit. I further understand that it is my responsibility to keep track of the number of visits I have used, the expiration date, and obtain a new referral as needed. I understand that should I fail to have a valid referral at the time of my visit, I will need to reschedule my appointment.

INSURANCE CARDS

All patients new and returning are required to present their insurance card(s) at every visit. I understand by signing below that I am responsible for notifying the office of any changes to my insurance or contact information.

Patient Signature: _____ Date: _____

CANCELLATION POLICY

Should you be unable to keep your appointment, please contact our office to cancel your appointment at your earliest convenience. Failure to contact our office within 24 hours of the appointment will result in a \$25.00 no-show fee. This fee is not reimbursable by your insurance company.

Patient Signature: _____ Date: _____

HIPAA POLICY

Patients 18 years of age or older are protected under the Federal Health Insurance Portability and Accountability Act. This federal law prohibits any staff member of **Monarch Dermatology** from discussing appointments, medications, test results, and/or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or care takers to obtain information on their behalf. If you would like to permit someone to discuss your medical condition or obtain results for you, please list their name(s) below. Only individuals names listed will be provided with information. Should you wish to update the names provided, please ask the receptionist at the front desk for a HIPPA form.

Name of Individual (please print) _____
Relationship to Patient _____
Name of Individual (please print) _____
Relationship to Patient _____
Name of Individual (please print) _____
Relationship to Patient _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was given the opportunity to review the Notice of Privacy. I understand a copy of the Privacy Practices is available upon my request (please ask our front desk staff).

Patient Signature: _____ Date: _____

Must be signed by patient 18 years or older. Patients under 18, must be signed by a parent or legal guardian.