RAPPAPORT DERMATOLOGY
PATIENT MEDICAL HISTORY(Requires update every 2 years)

Last Name_____First Name_____Middle_____
Date of Birth_____Occupation_____Primary Physician:_____
Did your primary doctor refer you to us? Y__ N___
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? Yes__No__
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: Yes__No__Novocaine Yes__No__Lidocaine
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? Yes____ No____. Please describe_____
_____

HAVE YOU HAD ANY OF THE FOLLOWING:

Y__N__Actinic Keratosis If yes,_____
Y__N__Anemia If yes,_____
Y__N__Anxiety/Depression If yes,_____
Y__N__Arthritis If yes,_____
Y__N__Asthma If yes,_____
Y__N__Biopsied Abnormal Moles If yes,_____
Y__N__Bipolar Disorder If yes,_____
Y__N__Bleed Easily If yes,_____
Y__N__Blood Clot If yes,_____
Y__N__Diabetes If yes,_____
Y__N__Dizziness/Fainting If yes,_____
Y__N__Ear Problems If yes,_____
Y__N__Eczema If yes,_____
Y__N__Exposure to HIV/AIDS If yes,_____
Y__N__Eye Problems If yes,_____
Y__N__Genetic Disease If yes,_____
Y__N__Hair Problems If yes,_____
Y__N__Hay Fever If yes,_____
Y__N__Headaches If yes,_____
Y__N__Heart AttackIf yes,_____
Y__N__Heart Surgery If yes,_____
Y__N__Hepatitis Virus If yes,_____

Y__N__High Blood Pressure If yes,_____
Y__N__Keloid Scars If yes,_____
Y__N__Kidney Trouble If yes,_____
Y__N__Liver Disorder If yes,_____
Y__N__Lung Disease If yes,_____
Y__N__Melanoma If yes,_____
Y__N__Mitral Valve Prolapse If yes,_____
Y__N__Nervous Disease If yes,_____
Y__N__Oral Sores If yes,_____
Y__N__Other Cancer If yes,_____
Y__N__Palpitations If yes,_____
Y__N__Problems with healing If yes,_____
Y__N__Psoriasis If yes,_____
Y__N__Radiation Treatment If yes,_____
Y__N__Seizure Disorder If yes,_____
Y__N__Sinus Trouble If yes,_____
Y__N__Skin Cancer if yes_____
Y__N__Stroke/TIA If yes,_____
Y__N__Thyroid Trouble If yes,_____
Y__N__Tuberculosis If yes,_____

List any other medical problems not listed above:
_____

(PLEASE TURN OVER AND COMPLETE BACK PAGE)

Page 2/Patient Medical History Form
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. __Yes __No. If yes, list_____
Covid Vaccines __Yes__No Covid Booster __Yes__No

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? Yes__No__ 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_____

I, certify that this information is to the best of my knowledge and believe is true, correct and complete.
_____ _____
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

Have you ever had any cosmetic procedures done? Y__N__ If yes, describe_____
_____

Are you currently using any cosmetic skin care products? Y__N__ If yes, describe_____
_____

Would you be interested in learning more about:
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__PDT(Photodynamic Therapy)
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__Chemical Peels
Y__N__Vibradermabrasion
Y__N__IPL Photofacials
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

Check out our website by scanning the code for more information or go to www.drrappaport.com

RAPPAPORT DERMATOLOGY

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Saratoga Springs, NY 12866
Telephone: (518) 587-9243

PATIENT INFORMATION

Today's Date_____
Last Name:_____First Name_____ Middle___
Mailing Address_____
City:_____State:_____ Zip Code_____
Date of Birth_____ Home Phone:_____Work Phone_____Cell Phone_____
Email Address:_____ Sex: Male__ Female__ Marital Status _____
REFERRAL INFORMATION: (Please check the appropriate box below to help us determine how you were referred to our office)
__Physician __Friend __Relatives __One of our patients __Yellow Pages __Insurance
Primary or Referring Physician:_____
Person to contact in case of emergency:_____Phone:_____
Other Family Members under Dr. Rappaport's Care:_____
To better serve our patients, we will automatically fax all prescriptions to the pharmacy for you:
Pharmacy:_____Phone:_____Fax_____
Pharmacy Location_____
RESPONSIBLE PARTY(If different from patient)
Last Name:_____First Name_____Middle___
Date of Birth:_____
INSURANCE COVERAGE-(Please present insurance card(s) to receptionist.
Primary Card HolderName:_____ Relationship to patient_____DOB:_____

AUTHORIZATION AND FINANCIAL POLICY

I, the undersigned certify that I (or my dependent) assign directly to I. Paul Rappaport, M.D., 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 copayments, coinsurance, deductibles, non-par insurance and self pay are due at the time services are rendered. I understand that I. Paul Rappaport, M.D. has the right to charge me $35 for any returned check and $50 for any office appointments and $150 for any procedures I fail to reschedule (No-Show Appointments)

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 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 Rappaport Dermatology's financial Policies.

Signed:_____ Date:_____
Patient or person authorized to consent signature
If Guardian, state relation:_____

We gladly accept Cash, Checks, MC, VISA, AMEX, DISCOVER. We also offer CARE CREDIT.