DEPARTMENT OF DERMATOLOGY

Stony Brook Medicine

Stony Brook Cancer Center
3 Edmund D. Pellegrino Road
2nd Floor, Dept. of Surgical Oncology
Stony Brook, NY 11794

Dear Patient,

We welcome you to Stony Brook Dermatology Associates. **You have been scheduled to see either Dr. Adam Korzenko or Dr. Jordan Slutsky at the Stony Brook Cancer Center.** It is important not to rush through the completion of these forms since important data requested such as your medical history must be accurate and thorough. If you are unsure of any section, leave it blank and we will assist you when you arrive.

Please remember to bring your completed forms, your insurance card so that we can make a copy for your medical record and your referral (if applicable). Insurance plans requiring referrals to authorize payment for medical services are the patient's responsibility to obtain. Please confirm they have been submitted electronically by the primary care physician (PCP) and or received by our office if a hard copy was sent in by fax (e.g., Blue Cross/Blue Shield HMO). If you need the ID# for the dermatologist you will be seeing here, we are more than happy to provide you with the information you need to expedite the referral process. **All (paper) referrals should be sent to fax# 631-638-4220.**

Once you have checked in with reception you will be seen by billing to verify your insurance eligibility and copayment responsibility. *We respectfully request a minimum 24 hour advance notice if you need to cancel or reschedule to avoid a "No Show" fee*. We understand you may have changes to your own schedule however our goal is to maximize appointment availability to ensure all patients on our wait list can avail themselves of unexpected appointment openings.

If you have any questions prior to your visit, please feel free to contact us @ 631-444-4200 and we will be happy to assist you.

Julie Bouziotis
Practice Manager

Stony Brook Dermatology Associates
181 Belle Mead Road Suite #5
East Setauket, New York 11733-9221
www.stonybrookphysicians.com
Phone: 631-444-4200 Nursing Fax: 631-444-4276 Reception Fax: 631-638-4220

a MAP for your convenience

- **From the L.I.E. (Long Island Expressway)** take exit 62 and follow signs for Route 97 North Nicolls Road. Continue on Nicolls Road past Nesconset Highway (Route 347) and make a right into the Hospital entrance. At the 1st traffic light make a left and travel all the way down the winding path to the glass building which is the Cancer Center.

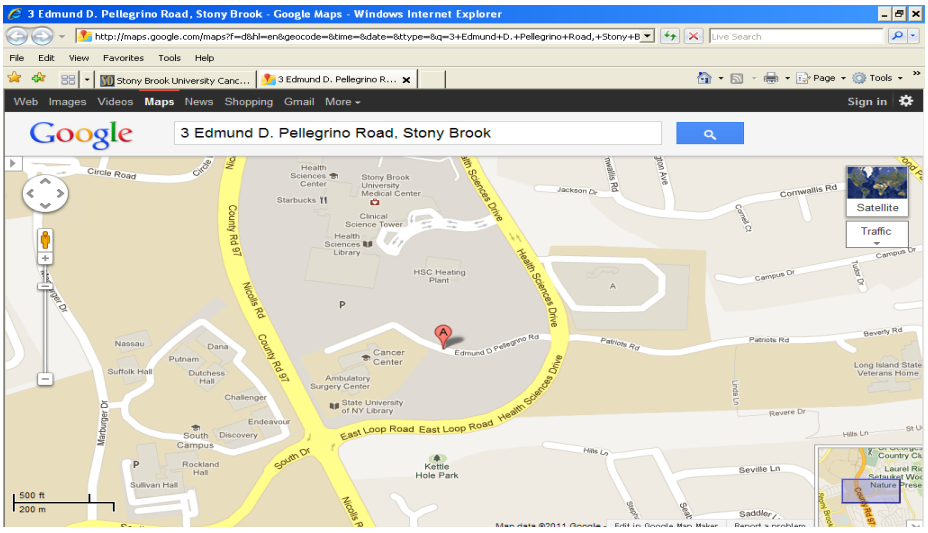
- **From Route 347 (Nesconset Highway) traveling East** make a left onto Nicolls Road traveling north and make a right into the Hospital entrance. At the 1st traffic light make a left and travel all the way down the winding path to the glass building which is the Cancer Center.

- **From Route 347 (Nesconset Highway) traveling West** make a right onto Nicolls Road traveling north and make a right into the Hospital entrance. At the 1st traffic light make a left and travel all the way down the winding path to the glass building which is the Cancer Center.

- **From the NS (Northern State Parkway)** please follow it to the end and follow signs for Route 347 (Nesconset Highway). Make a left onto Nicolls Road traveling north and make a right into the Hospital entrance. At the 1st traffic light make a left and travel all the way down the winding path to the glass building which is the Cancer Center.

- **From 25A traveling East** make a right onto Nicolls Rd. traveling south and make a left into the Hospital entrance. Take the winding path all the way down to the traffic light just before Nicolls Road (Edmund D. Pellegrino Road) and make a right. This road will take you directly to the glass building which is the Cancer Center.

- **From 25A traveling West** make a left onto Nicolls Road traveling south and make a left into the Hospital entrance. Take the winding path all the way down to the traffic light just before Nicolls Road (Edmund D. Pellegrino Road) and make a right. This road will take you directly to the glass building which is the Cancer Center.



State University of New York
UNIVERSITY HOSPITAL
AND MEDICAL CENTER
Stony Brook, New York 11794

AMBULATORY CARE SUMMARY LIST

Service: _____

Service Phone # _____

Pt. Name: _____

M.R.#: _____

D.O.B.: _____

Phone (h)_____

(c)_____

(w)_____

Ambulatory Care Guide Given ☐ (date) _____

Advanced Directive Documents Received from Patient ☐ (date) _____

Allergies / Adverse Reactions (Describe) ☐ **No Known Allergies**

Allergy	Description	Allergy	Description	Allergy	Description

Diagnoses/ Medical Conditions

DATE		DATE RESOLVED	DATE		DATE RESOLVED

Heart valve problems such as MVP? Yes No
Artificial joints? Yes No
Hepatitis? Yes No
Pacemaker/Defibrillator? Yes No

Do you need antibiotic prophylaxis? Yes No
If yes, please list_____

Past Operative/Invasive Procedures

Past Operative/Invasive Procedure	Date	Past Operative/Invasive Procedure	Date

Medications (prescribed for or used by the patient)

Start Date	Medication Name	Dose	Route	Frequency	Stop Date

Name: _____

FAMILY HISTORY: Please indicate if there is a family history of any skin conditions or cancers
Y N Relationship to you – Father/Mother/Sister/Brother/Other_____

MEDICAL HISTORY: Please circle yes or no if you **have** or **have had** any of the following:

Y N HEART DISEASE
Y N HIGH BLOOD PRESSURE
Y N BREATHING PROBLEMS
Y N DIABETES
Y N THYROID DISEASE
Y N PROSTATE DISORDER
Y N LIVER DISORDER
Y N STOMACH/INTESTINAL DISORDER
Y N BLEEDING DISORDER
Y N JOINT PAIN
Y N EAR OR EYE DISORDER
Y N MIGRAINES
Y N HIV/AIDS

Y N STROKE
Y N CANCER
Y N SKIN CANCER
Y N ANY SKIN DISEASE
Y N PSYCHIATRIC CONDITION
Y N SEIZURES
Y N WEIGHT LOSS
Y N OTHER_____

SOCIAL HISTORY

1. Do you use Tobacco Y N If yes, how much_____

2. Do you use Alcohol Y N Social Weekends Daily

3. Occupation _____

4. SINGLE MARRIED DIVORCED WIDOWED

Females only:

5. Are you pregnant? Y N 6. Are you planning to become pregnant? Y N

7. Are you breast feeding? Y N

NURSE/MA / ID#_____RESIDENT/ ID#_____

☐ I REVIEWED THE ABOVE ROS/PFSH WITH MY PATIENT

ATTENDING /ID#_____

DATE FORM INITIATED_____

AC2C030

STONY BROOK UNIVERSITY MEDICAL CENTER

ADULT PATIENT NEEDS ASSESSMENT

Communication:

Do any of the following apply to you?

☐ Impaired Vision
☐ Impaired Hearing
☐ Reading or Speaking Problems
☐ Pain
☐ Concerns about your illness
☐ None of the above
☐ Other _____

What is your primary language? _____

Do you have difficulty understanding English? ☐ Yes ☐ No

Can you read English? ☐ Yes ☐ No

What language do you prefer when receiving information? _____

Culture:

Do you have any Cultural/ Religious/ Spiritual Practices that are important for us to know to provide your health care?

☐ Yes ☐ No If Yes, please describe_____

_____

Learning Preference:

How do you prefer to learn?

☐ Reading ☐ Person explaining to me ☐ Seeing/pictures ☐ Demonstration ☐ Video/Television

Is there anyone you would like to have with you during your teaching? If so, whom? _____

Domestic Concerns:

Have you been a victim of mental or physical abuse? ☐ Yes ☐ No

Do you feel that you are currently in danger at home? ☐ Yes ☐ No

Falls Risk:

Do you have a fear of falling? ☐ Yes ☐ No

Have you fallen in the last 12 months? ☐ Yes ☐ No

If you answered "YES" to either of these two questions, please notify staff immediately.

Nutrition Screen:

Have you noticed a decrease in appetite within the last month? ☐ Yes ☐ No

Have you had an unexplained weight loss (over 10 lb.) over the past 3-6 months? ☐ Yes ☐ No

Please describe your appetite: ☐ Good ☐ Fair ☐ Poor ☐ Other _____

Patient/Designee Signature: _____Date: _____

Practitioner Signature:_____ ID#:_____ Date: _____Time: _____

Stony Brook Dermatology Associates

Stony Brook Medicine

Please complete our patient registration form.

Title: □Mr. □Mrs. □Ms. □Miss □Dr

Name: _____ _____
Last **First** **MI**

Address: _____
Street # **Street Name** **Apt#**

_____
City **State** **Zip**

Home Phone#_____**Cell phone#**_____

Social Security # _____

Employer: _____
Name **Address**

Health Insurance:
Primary _____

Secondary _____

Patient relationship to policyholder □ **Self** □ **Spouse** □ **Child** □ **Other**

Primary/Family Physician Name & Address

_____

_____

Phone #_____

Referring Physician Name & Address

_____

_____

Phone #_____

DOES YOUR INSURANCE REQUIRE A REFERRAL O YES O NO

PLEASE PRESENT YOUR INSURANCE CARDS TO THE RECEPTIONIST SO COPIES CAN BE MADE.

DO WE HAVE YOUR PERMISSION TO:

LEAVE A MESSAGE ON YOUR ANSWERING MACHINE □ **YES** □ **NO**

DISCUSS YOUR MEDICAL CONDITION WITH ANY MEMBER OF YOUR HOUSEHOLD □ **YES** □ **NO**

IF YES, WHOM:_____ **RELATIONSHIP**_____

_____

PATIENT (OR GUARDIANS) SIGNATURE **DATE**

Stony Brook Medicine
STONY BROOK
Stony Brook Southampton Hospital
Stony Brook Eastern Long Island Hospital
Stony Brook Care

Ambulatory Care Consent Form

Patient Name: _____ Date of Birth: _____

MRN: _____ Enc#: _____

By signing below I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the Hospital and its staff.

_____
Signature of Patient or Patient Representative

_____
Print Name of Patient or Personal Representative

_____
Relationship, if signed by person other than Patient

_____
Date

_____
Description of Personal Representative's Authority