Henry C. Gasiorowski, M.D.

Michele E. Gasiorowski, M.D.

PATIENT INFORMATION

40 West Elm Street
Greenwich, CT 06830
Telephone: 203-661-7546
Facsimile: 203-661-0085

Patient: (Mr. Mrs. Ms. Miss) Last:____ **First:**____________________________

Street: _______________________________________ **City:**_____________________ **State:**________ **Zip:**_______________

Email: ____ *(email address will never be released to an unauthorized party)*

Home Phone:________________________ **Cell Phone:** ___________________________ **Work Phone:**_____________________

Birthdate:______________________ **(Age:** __________ **)**

Male: ___________ **Female:** ___________

Social Security # ________________________________ **Drivers License #:** ______________________________________

Marital Status: • Single • Married • Other Spouse Name:
____

Employer:____ Work Phone: ____________________________

Address:___________________________________ City:______________________ State:__________ Zip:______________

RESPONSIBLE PARTY : Parent (if minor) Last: _________________________________ First: ___________________________

Social Security #:_________________________ Date of Birth: __________________ Phone:___________________________

Address: ___________________________________ City: _______________________ State:_________ Zip:______________

**** WHO RECOMMENDED US? • Friend • Family • Website • M.D. • Media • Other:***____________________________

*** IS MEDICARE YOUR PRIMARY INSURANCE? Yes or No**

MEDICARE POLICY:
Since February 1998, our office has privately contracted with our Medicare participants. This means that you may still be seen in our office, however, you will be responsible to pay your bill at regular office prices **minus a 20% courtesy** on all
non-cosmetic procedure if Medicare is your primary insurance and you are over the age of 65. These charges cannot be submitted to Medicare by our office and Medicare will not pay for services provided in our office. Your secondary carrier may or may not consider these charges and may alter their reimbursement accordingly

BILLING POLICY:
The policy of this office requires payment at the time of services are rendered. Certain surgical procedures may require advance payment or deposit. We do not participate with any insurance plans. You will be furnished with a receipt for your insurance company to reimburse you directly providing you attach the copy of your bill to your claim form. Please call your insurance company for claim submission instructions. Under certain circumstances, additional information may be necessary to process your claim. Your signature below authorizes this office to release any medical information requested. You are responsible for payment in full regardless of any insurance company's determination of usual and customary rates.

CANCELLATION POLICY:
I understand that I will be charged an office visit starting with the third late cancellation or missed appointment unless I notify the office 24 hours prior to my scheduled appointment.

SIGNED: ____ **DATE:**____________________

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Patient Name:________________________________

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Reason for today's visit:

____

____

Medical History:

- Anxiety
- Arthritis
- Asthma
- Atrial fibrillation
- Bone Marrow
- Transplantation
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD
- Hearing loss
- Hepatitis
- High blood pressure
- HIV/AIDS
- High Cholesterol
- Thyroid Problems
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- NONE

____

____

The following questions are for female patients only:

Do you have polycystic ovaries? ________
Do you have menstrual periods? ________
If so, are your periods regular? ________

Are you pregnant? ________
Are you planning a pregnancy? ________
Do you take oral contraceptives (OCC)? _______

Do OCC's make your skin uneven? _______
Are you on hormone treatments? _______
Do you have new facial hair growth? _______
Easy yeast infections? _______

Surgical History:

____

____

Skin History:

- Acne
- Actinic Keratoses
- Asthma
- Basal Cell Skin Cancer
- Blistering Sunburns
- Dry Skin
- Eczema
- Flaking or itchy scalp
- Hay Fever/Allergies
- Melanoma
- Poison Ivy
- Precancerous Moles
- Psoriasis
- Squamous Cell Skin Cancer
- *Abnormal moles*
- *Chronic skin conditions*
- *History of keloids or thick scars*

- *Eczema or atopic dermatitis*
- *X-ray or Grenz ray treatments*
- *NONE*

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Patient Name:_________________________________

Skin Type:

• Caucasian • Hispanic • African American • Mediterranean • American Indian • Multiracial • Other_____________

Fitzpatrick I – VI:

Check one (when exposed to the sun without protection for approximately 1 hour):

- *I - Always burns, never tans*
- *II - Usually burns, tans less than average*
- *III - Sometimes mild burn, tans about average*
- *IV - Rarely burns, tans more than average*
- *V - Rarely burns, tans profusely*
- *VI - Never burns, deeply pigmented*

Do you wear Sunscreen: Yes No (SPF __________)
Do you tan in a tanning salon? Yes No
Do you have a family history of Melanoma Yes No

Family History:

Has anyone in your family ever had the following:

- *Diabetes*
- *Systemic Lupus Erythematosus*
- *Scleroderma*
- *Psoriasis*
- *Vitiligo*
- *Asthma, Eczema or Hives*
- *Melanoma*
- *Non-melanoma skin cancer*

Medications

List all medications you are taking, including vitamins, laxatives, pain relievers and herbal remedies:

____

Allergies:

____

Patient Social History:

Use of Tobacco • Currently smokes • Occasional • Never • Former- *(quit: __________)*
Use of Alcohol • 3 or more per day • 1–2 per day • less than 1 per day • None • Former *(quit: ________)*
Use of Recreational Drugs • Occasional • Never • Former (quit: ____________)

SIGNED: ____ **DATE**:________________