Amy Wechsler, MD
Laura Dyer, PA-C
Dermatology

Welcome To Our Office!

1. Your appointment time is reserved for you. If you must reschedule an appointment, please try to do so in a timely fashion so that another patient may be accommodated and you can be rescheduled promptly. **Appointments cancelled within less than 24 hours or "no shows" will incur the full office fee for the time reserved.** _____ (Please initial)

2. We will call or email you to confirm your appointment within the week prior to your appointment. Please provide us with your best contact number(s) and/or email on the patient information sheet. _____ (Please initial)

3. Telephone calls from patients and their parents (if under 18) are welcome during office hours. Every effort will be made to return calls promptly. If a call is for an illness or an emergency, please inform the office staff at the time of your call. _____ (Please initial)

Please do not hesitate to ask any questions pertaining to office procedure or other concerns you may have. We value communication and an open, trusting relationship with our patients.

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Name _____
First Middle Initial Last

Date of Birth ____/____/____ Age _____ Sex ___F ___M

S.S. # _____ Marital Status __single __married __domestic partner __divorced __widowed

Address _____
Street Address Apt #

_____
City State Zip

Please only list number(s) that you would like us to contact you at:
Home (_____) _____-_____ Work (_____) _____-_____ Cell (_____) _____-_____
Email _____
Pharmacy _____ Phone (_____) _____-_____

May we discuss your medical condition with another family member? ___Yes ___No
If yes, whom _____ relationship _____

How were you referred to our practice? _____
Do we take care of any of your family members? ___Yes ___No
If yes, please list_____
_____
In case of emergency _____ home/cell# (_____) _____-_____
Relationship _____ work# (_____) _____-_____

If patient is a minor (under 18) please enter responsible party information.
Name _____
First Middle Initial Last
Address _____
Street Address Apt #

_____
City State Zip

Home (_____) _____-_____ Work (_____) _____-_____ Cell (_____) _____-_____

Patient/Parent's Signature _____ Date _____

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Patient Financial Policy

This practice is fee for service only; complete payment for all services is required at the time of service. Currently, the practice does not accept any insurance plans including medicare. We accept Cash, Checks, Master Card, Visa, American Express, and Discover for your convenience in paying.

At the end of each visit, you will receive a personal itemized receipt along with an insurance receipt for all insurance covered services only after payment is received. Please be sure to call your insurance company ahead of time to discuss your out of network benefits as every insurance plan differs.

If at any time you have any questions about the cost of a procedure proposed by Dr. Wechsler, we will be happy to discuss the cost with you.

I certify that I have read and understand the financial policy of Amy Wechsler, MD and agree to abide by the policy.

Signature _____ Date _____

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Medical History

Patient _____ Date_____

Reason for today's visit _____

Please list all current medications (including creams, lotions, ointments, over the counter medications, vitamins, herbals)

1 _____ 2 _____ 3_____

4 _____ 5 _____ 6 _____

Have you ever had dental anesthesia (Novocaine)? ___Yes ___No
Any bad reaction? ___Yes ___No

Are you allergic to any medications? ___Yes ___No If yes, please list below:

1 _____ 2 _____ 3_____

4 _____ 5 _____ 6 _____

Are you up-to-date on all immunizations? ___Yes ___No

Do you have now, or have ever had diseases or conditions of:

Lungs:	Yes	No
Bronchitis	___	___
Emphysema	___	___
Asthma	___	___
Chronic Cough	___	___
Morning Cough	___	___
Shortness of breath	___	___
Wheezing	___	___

Cardiovascular:	Yes	No
High Blood Pressure	___	___
Chest Pain	___	___
Heart Attack	___	___
Irregular Heartbeat	___	___
Phlebitis	___	___
Inflammation of vein	___	___
Blood Clots	___	___
Pacemaker	___	___

Other Systemic	**Yes**	**No**
Anxiety	___	___
AIDS	___	___
Arthritis/Joint Deformity	___	___
Arthralgia	___	___
Limited Motion	___	___
Artificial Joint(s)	___	___
Bladder	___	___
Bipolar Disorder	___	___
Convulsions, Epilepsy or Seizures	___	___
Depression	___	___
Diabetes	___	___
Fainting	___	___
Gastrointestinal	___	___
Nausea/vomiting/diarrhea when taking antibiotics	___	___
Hepatitis	___	___
Herpes/Cold sores	___	___
HIV	___	___
Kidney	___	___
Thyroid	___	___
Yeast infection when taking antibiotics	___	___

Please list any other medical or psychiatric conditions or diseases:

_____

Please list any surgical procedures:

_____
Type of surgery Date

_____
Type of surgery Date

Have you ever had skin cancer? ___Yes ___No

If yes, where_____ Type of Skin Cancer_____

Have you ever had cancer? ___Yes ___No If yes, type: _____

Has anyone in your family had skin cancer? ___Yes ___No

If yes, whom_____ Type of Skin Cancer_____

Do you have a history of any specific skin diseases? ___Yes ___No
Do you have problems with healing? ___Yes ___No
Do you develop keloids (scars) after surgery? ___Yes ___No
Do you bleed easily? ___Yes ___No
Do you have any tattoos or permanent makeup? ___Yes ___No

Do you develop skin rashes in reaction to:
___Medications ___Food ___Environment ___Bandages ___Topical Neosporin
___Other

Social History

Do you drink alcohol? ___Yes ___ No If yes _____ drinks per week
Do you use IV drugs? ___Yes ___No If yes, what? _____ How often? _____
Do you smoke? ___Yes ___No If yes, how much?_____

What is your occupation?_____

If student, where? _____

For women only:

Do you have irregular periods? ___Yes ___No
Are you breast feeding? ___Yes ___No
Are you pregnant? ___Yes ___No
Completed by: ___Patient ___MA (initials)

Signed by Patient/Guardian _____Date_____

Reviewed by _____ Date_____

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Cosmetic Interest Questionnaire

Patient _____ Date _____

Health issues and procedures or products of interest to you (check all that apply)

___ Acne
___Acne Scar Reduction
___ Birthmarks
___ Body Contouring
___ Botox® Cosmetics
___ Chemical Peels
___ Coolsculpting
___ Excessive Sweating
___ Eyelashes: Longer, Thicker, Darker
___ Facial Rejuvenation
___ Frown lines between the brows
___ Hair Removal
___ Laser Treatments
___ Lines around nose and mouth
___ Liver Spots/ Age Spots
___ Micro-Dermabrasion
___ Mole or Scar Reduction
___ Red Spots/ Rosacea
___ Removing Facial Vessels
___ Removing Leg Veins
___ Restylane or Other Fillers
___ Scar Reduction
___ Skin Care Advice
___ Skin Care Products
___ Spider Vein Treatments
___ Sunscreen Advice
___ Wrinkle Reduction/ Therapy

___Other, please specify:

_____

Amy Wechsler, M.D., P.C.
Laura Dyer, PA-C
45 East 85th Street
New York, NY 10028
P: 212-396-2500
F: 212-396-2505

Authorization for Release of Information

Name _____ DOB _____

I hereby authorize Dr. Amy Wechsler to release my records, obtain my records and/or verbally exchange my records with other service providers in order to provide me with the appropriate medical care.

I understand that this authorization may be revoked by me in writing at any time; except to the extent that action has already been taken.

Patient Signature _____ Date _____

Parent/Guardian, if minor _____