

**Amy Wechsler, MD Gervaise Gerstner, MD**  
***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 visit 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 procedures or other concerns you may have. We value communication and an open, trusting relationship with our patients.



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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 any 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, M.D., and Gervaise Gerstner, M.D., and agree to abide by the policy.

Signature\_\_\_\_\_Date\_\_\_\_\_

# Dermatology Medical History

Patient \_\_\_\_\_ Date \_\_\_\_\_

Reason for today's visit

\_\_\_\_\_

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

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_

4 \_\_\_\_\_ 5 \_\_\_\_\_ 6 \_\_\_\_\_

**Have you ever had dental anesthesia (Novocaine) ? No \_\_\_ Yes \_\_\_**

**Any bad reaction? No \_\_\_ Yes \_\_\_**

**Are you allergic to any medications? No \_\_\_ Yes \_\_\_ If yes, please list below:**

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_

4 \_\_\_\_\_ 5 \_\_\_\_\_ 6 \_\_\_\_\_

**Are you up-to-date on all immunizations? No \_\_\_ Yes \_\_\_**

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

<b>Lungs:</b>	<b>Yes</b>	<b>No</b>	<b>Other Systemic:</b>	<b>Yes</b>	<b>No</b>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	On Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/vomiting/diarrhea when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
			Yeast Infection when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
			Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
			Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
			Limited motion	<input type="checkbox"/>	<input type="checkbox"/>
			Artificial Joint (s)	<input type="checkbox"/>	<input type="checkbox"/>
			Convulsions, Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>
			Fainting	<input type="checkbox"/>	<input type="checkbox"/>
			Herpes/Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>
			HIV	<input type="checkbox"/>	<input type="checkbox"/>
			AIDS	<input type="checkbox"/>	<input type="checkbox"/>
			Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>

  

<b>Cardiovascular:</b>	<b>Yes</b>	<b>No</b>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of vein	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>

**Please list any other medical conditions or diseases:**

\_\_\_\_\_

**Please list any surgical procedures:**

\_\_\_\_\_  
Type of Surgery \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Type of Surgery \_\_\_\_\_ Date \_\_\_\_\_

**Skin:**

Have you ever had skin cancer? Yes \_\_\_ No \_\_\_

If yes, where \_\_\_\_\_ Type of Skin cancer \_\_\_\_\_

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? \_\_\_\_\_

**For women only:**

Do you have irregular periods? Yes \_\_\_ No \_\_\_ Are you pregnant? Yes \_\_\_ No \_\_\_

Are you breast feeding? Yes \_\_\_ No \_\_\_ Completed by: Patient \_\_\_\_\_ MA \_\_\_\_\_ (initials)

**Signed by Patient** \_\_\_\_\_ **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)**

- |   |   |
|---|---|
| <input type="checkbox"/> Acne                               | <input type="checkbox"/> Micro-Dermabrasion         |
| <input type="checkbox"/> Acne Scar Reduction                | <input type="checkbox"/> Mole or Scar Removal       |
| <input type="checkbox"/> Birthmarks                         | <input type="checkbox"/> Red Spots/Rosacea          |
| <input type="checkbox"/> Botox® Cosmetic                    | <input type="checkbox"/> Removing Facial Vessels    |
| <input type="checkbox"/> Chemical Peels                     | <input type="checkbox"/> Removing Leg Veins         |
| <input type="checkbox"/> Excessive Sweating                 | <input type="checkbox"/> Restylane or Other Fillers |
| <input type="checkbox"/> Eyelashes: Longer, Thicker, Darker | <input type="checkbox"/> Scar Reduction             |
| <input type="checkbox"/> Facial Rejuvenation                | <input type="checkbox"/> Skin Care Advice           |
| <input type="checkbox"/> Frown lines between the brows      | <input type="checkbox"/> Skin Care Products         |
| <input type="checkbox"/> Hair Removal                       | <input type="checkbox"/> Spider Vein Treatment      |
| <input type="checkbox"/> Laser Treatments                   | <input type="checkbox"/> Sunscreen Advice           |
| <input type="checkbox"/> Lines around nose and mouth        | <input type="checkbox"/> Wrinkle Reduction/Therapy  |
| <input type="checkbox"/> Liver Spots/Age Spots              |   |
| <input type="checkbox"/> Other, please specify:             |   |

\_\_\_\_\_