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.
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 ________
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 ________________
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:

<table>
<thead>
<tr>
<th>Lungs:</th>
<th>Yes</th>
<th>No</th>
<th>Other Systemic</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Bronchitis</td>
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<td>Anxiety</td>
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<td>Emphysema</td>
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<td>AIDS</td>
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<td>Asthma</td>
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<td>Arthritis/Joint Deformity</td>
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<td>Chronic Cough</td>
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<td>Arthralgia</td>
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<td>Morning Cough</td>
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<td>Limited Motion</td>
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<td>Shortness of breath</td>
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<td>Artificial Joint(s)</td>
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<td>Wheezing</td>
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<td>Bladder</td>
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<td>Bipolar Disorder</td>
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<td>Convulsions, Epilepsy or Seizures</td>
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<td>Depression</td>
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<td>Diabetes</td>
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<td>Fainting</td>
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<td>Gastrointestinal</td>
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<td>Nausea/vomiting/diarrhea</td>
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<td>when taking antibiotics</td>
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<td>Hepatitis</td>
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<td>Herpes/Cold sores</td>
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<td>HIV</td>
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<td>Kidney</td>
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<td>Thyroid</td>
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<td>Yeast infection when taking antibiotics</td>
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</table>
Please list any other medical or psychiatric conditions or diseases:
_____________________________________________________________________________________

Please list any surgical procedures:
_____________________________________________________________________________________

<table>
<thead>
<tr>
<th>Type of surgery</th>
<th>Date</th>
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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 pregnant? ___Yes ___No
Are you breast feeding? ___Yes ___No

Completed by: ___Patient ___MA (initials)

Signed by Patient/Guardian ________________________________________________ Date________

Reviewed by __________________________________________________________ Date________
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:
________________________________________________________________________
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 _________________________