

**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.

**Amy Wechsler, MD**  
**Laura Dyer, PA-C**  
**Dermatology**

Name \_\_\_\_\_  
First
Middle Initial
Last

Date of Birth \_\_\_/\_\_\_/\_\_\_      Age \_\_\_\_\_      Gender \_\_\_F\_\_\_M\_\_\_ Non-binary

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 \_\_\_\_\_

Amy Wechsler, MD

Laura Dyer, PA-C

Dermatology

Medical History

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

Reason for today's visit \_\_\_\_\_

Please list all current medications (including birth control, hormone replacement therapies, creams, ointments, over the counter medications, vitamins and 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:

<b>Lungs:</b>	Yes	No	<b>Other Systemic</b>	Yes	No
Bronchitis	___	___	Anxiety	___	___
Emphysema	___	___	AIDS	___	___
Asthma	___	___	Arthritis/Joint Deformity	___	___
Chronic Cough	___	___	Arthralgia	___	___
Morning Cough	___	___	Limited Motion	___	___
Shortness of breath	___	___	Artificial Joint(s)	___	___
Wheezing	___	___	Bladder	___	___
			Bipolar Disorder	___	___
			Convulsions, Epilepsy or Seizures	___	___
			Depression	___	___
<b>Cardiovascular:</b>	Yes	No	Diabetes	___	___
High Blood Pressure	___	___	Fainting	___	___
Chest Pain	___	___	Gastrointestinal	___	___
Heart Attack	___	___	Nausea/vomiting/diarrhea when taking antibiotics	___	___
Irregular Heartbeat	___	___	Hepatitis	___	___
Phlebitis	___	___	Herpes/Cold sores	___	___
Inflammation of vein	___	___	HIV	___	___
Blood Clots	___	___	Kidney	___	___
Pacemaker	___	___	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

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 \_\_\_\_\_

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**Laura Dyer, PA-C**

**Dermatology**

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"/> Lines around nose and mouth |
| <input type="checkbox"/> Acne Scar Reduction                | <input type="checkbox"/> Liver Spots/ Age Spots      |
| <input type="checkbox"/> Birthmarks                         | <input type="checkbox"/> Micro-Dermabrasion          |
| <input type="checkbox"/> Body Contouring                    | <input type="checkbox"/> Mole or Scar Reduction      |
| <input type="checkbox"/> Botox® Cosmetics                   | <input type="checkbox"/> Red Spots/ Rosacea          |
| <input type="checkbox"/> Chemical Peels                     | <input type="checkbox"/> Removing Facial Vessels     |
| <input type="checkbox"/> Coolsculpting                      | <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 Treatments      |
| <input type="checkbox"/> Laser Treatments                   | <input type="checkbox"/> Sunscreen Advice            |
|   | <input type="checkbox"/> Wrinkle Reduction/ Therapy  |

Other, please specify:

\_\_\_\_\_

**Amy Wechsler, M.D., P.C.**

**Laura Dyer, PA-C**

**45 East 85<sup>th</sup> 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 \_\_\_\_\_