GERVAISE GERSTNER, M.D.
Dermatology

730 Park Avenue/50 East 71st Street
New York 10021
TEL 212.249.2208, FAX 212.249.2263
www.Gerstnermd.com

Welcome To My Office!

Thank you for choosing Gervaise Gerstner, M.D. Dermatology for your skin care needs.

Dr. Gervaise Gerstner is a board-certified dermatologist with a passion for combining the inherent art of her practice with the latest technologies available to help individuals achieve their desired results. Dr. Gerstner treats men and women of all ages and enjoys the process of guiding patients from addressing their initial concerns to helping them maintain a lifelong commitment to optimal skin health.

We are happy to welcome you as our newest patient! We wish to make your visits informative and your procedures a satisfying and pleasant experience. Please do not hesitate to ask any questions regarding office procedures or other concerns you may have. We value communication and an open, trusting relationship with our patients.

Thank you again for choosing Gervaise Gerstner, M.D. Dermatology.

Your appointment time is reserved for you. If you need to cancel or reschedule an appointment, please be sure to call and advise our office within 24 hours. Appointments cancelled within less than 24 hours or "no shows" will incur the full office visit fee for the time reserved.

_____ (Please initial)

We will call or email you prior to confirm the date and time of your appointment. Please provide us with your best contact number(s) and/or email on the patient information sheet.

_____ (Please initial)

Telephone calls from patients and their guardians (if patient is 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)

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NEW PATIENT REGISTRATION FORM

CONFIDENTAL PATIENT INFORMATION P1

Patient's Name: _____
(First) (Middle Initial) (Surname)

Date of Birth (MM/DD/YY) __/__/____

Age : _____

Address: _____
(Street name) (Apt/Floor Number)

Marital status
☐ Single ☐ Married ☐ Divorced
☐ Widowed

_____
(City) (State) (Zip)

Social Security Number
_____

Contact Details
Please only list contact numbers and an email addresses you would like us to contact you on:

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

Please check to authorize appointment reminders via text and/or email ☐

Email Address: _____

In Case of Emergency Contact
Name _____
Home (_____)_____ _____
Work (_____)_____ _____
Cell (_____)_____ _____
Relation (i.e. Spouse, guardian) _____

Consent to share information with family members / Friends
Yes ☐ **No** ☐
If yes, please list relevant names and contact numbers
Name _____ PH: _____
Name _____ PH: _____

How did you hear about Dr. Gerstner?
☐ Internet ☐ Magazine
☐ Family _____
☐ Friend _____
☐ Other _____

IF PATIENT IS A MINOR (UNDER 18) PLEASE ENTER RESPONSIBLE/GUARDIAN PARTY INFORMATION

Name: _____
(First) (Middle Initial) (Surname)

Date of Birth (MM/DD/YY) __/__/____

Address: _____
(Street name) (Apt/Floor Number)

Contact Details
Home (_____)_____
Cell (_____)_____
Email Address: _____

_____
(City) (State) (Zip)

I hereby certify that the above statements are true and correct to the best of my knowledge

Patient/Guardian signature _____ **Date** _____

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DERMATOLOGY MEDICAL HISTORY

CONFIDENTAL PATIENT INFORMATION P2

Main reason for your visit today? _____

MEDICATIONS

Please list (or show us your own printed record) all prescriptions and non-prescription medications. This includes vitamins, herbs, supplements, home remedies, birth control pills, inhalers, over the counter pain pills (Advil, Aleve, Tylenol, etc).

Are you currently taking any medication

☐ **YES**

☐ **NO**

If Yes, please any medication allergies you have

Name of Medication	Dose (e.g. mg/pill)	How many times per day
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6.		

PHARMACY

Pharmacy Name _____

Phone number _____ **Fax Number** _____

Address: _____

(Street name)

_____

(City) (State) (Zip)

ALLERGIES

Do you have any allergies to medication?

☐ **YES**

☐ **NO**

If **Yes**, please list any medication allergies you have:

_____

Have you had dental anesthesia (Novocain) in the past?

☐ **YES** ☐ **NO**

If you answered Yes, did you experience a bad reaction? ☐ **YES** ☐ **NO**

IMMUNISATIONS

Are you up to date on all immunizations?

☐ **YES** ☐ **NO** ☐ **UNSURE**

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CONFIDENTAL PATIENT INFORMATION P3

CURRENT OR PAST MEDICAL CONDITIONS

Please check the relevant conditions

Lungs			**Other Systemic**		
Asthma	☐ **YES**	☐ **NO**	AIDS / HIV	☐ **YES**	☐ **NO**
Bronchitis	☐ **YES**	☐ **NO**	Arthralgia	☐ **YES**	☐ **NO**
Chronic Cough	☐ **YES**	☐ **NO**	Arthritis/Joint Deformity	☐ **YES**	☐ **NO**
Emphysema	☐ **YES**	☐ **NO**	Artificial Joint(s)	☐ **YES**	☐ **NO**
Morning Cough	☐ **YES**	☐ **NO**	Bladder	☐ **YES**	☐ **NO**
Shortness of breath	☐ **YES**	☐ **NO**	Convulsions, Epilepsy or seizures	☐ **YES**	☐ **NO**
Wheezing	☐ **YES**	☐ **NO**	Diabetes	☐ **YES**	☐ **NO**
Cardiovascular			Fainting	☐ **YES**	☐ **NO**
Blood Clots	☐ **YES**	☐ **NO**	Gastrointestinal Nausea/vomiting/diarrhea when taking antibiotics	☐ **YES**	☐ **NO**
Chest Pain	☐ **YES**	☐ **NO**	Glaucoma	☐ **YES**	☐ **NO**
Heart Attack	☐ **YES**	☐ **NO**	Hepatitis	☐ **YES**	☐ **NO**
Heart Murmur	☐ **YES**	☐ **NO**	Herpes/Cold Sores		
High Blood Pressure	☐ **YES**	☐ **NO**	Kidney	☐ **YES**	☐ **NO**
Irregular Heartbeat	☐ **YES**	☐ **NO**	Limited motion	☐ **YES**	☐ **NO**
Inflammation of vein	☐ **YES**	☐ **NO**	On Dialysis	☐ **YES**	☐ **NO**
Pacemaker	☐ **YES**	☐ **NO**	Thyroid	☐ **YES**	☐ **NO**
Phlebitis	☐ **YES**	☐ **NO**	Yeast Infection when taking antibiotics	☐ **YES**	☐ **NO**

Other _____

_____

_____

SURGICAL PROCEDURES (Type and Date)

1. _____

Type Date

2. _____

Type Date

3. _____

Type Date

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CONFIDENTAL PATIENT INFORMATION P4

SKIN

Have you ever had skin cancer?

☐ **YES**
☐ **NO**

If Yes, please advise the **TYPE** and **WHERE**

_____

Has anyone in your family had skin cancer?

☐ **YES**
☐ **NO**

If Yes, please advise **WHOM** and **TYPE** of skin cancer

_____

Do you have a history of any specific skin diseases?

☐ **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, **HOW MANY** per week

_____

Do you use IV drugs?

☐ **YES**
☐ **NO**

If Yes, **WHAT?**

_____

Do you smoke?

☐ **YES**
☐ **NO**

If Yes, HOW MANY per week

_____

What is your occupation?

_____

Patients Signature

_____

OTHER

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**

FOR WOMEN ONLY

Do you have irregular periods?

☐ **YES**
☐ **NO**

Are you pregnant?

☐ **YES**
☐ **NO**

Are you breastfeeding?

☐ **YES**
☐ **NO**

Date

_____

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COSMETIC INTEREST QUESTIONNAIRE

Patient's Name: _____

(First) (Middle Initial) (Surname)

☐ **Acne**	☐ **Liver Spots/ Age Spots**
☐ **Acne Scar Reduction**	☐ **Micro-Dermabrasion**
☐ **Birthmarks**	☐ **Mole or Scar**
☐ **Botox® Cosmetic**	☐ **Red Spots/Rosacea**
☐ **Chemical Peels**	☐ **Removing Facial Vessels**
☐ **Excessive Sweating**	☐ **Sunscreen Advice**
☐ **Eyelashes: Longer, Thicker, Darker or**	☐ **Juvederm or Other Fillers**
☐ **Extensions**	☐ **Scar Reduction**
☐ **Facial Rejuvenation**	☐ **Skin Care Advice**
☐ **Frown lines between the brows**	☐ **Spider Vein Treatment**
☐ **Hair Removal**	☐ **Fat Reduction (Contouring)**
☐ **Laser Treatments**	☐ **Wrinkle Reduction/Therapy**
☐ **Lines around nose and mouth**	☐ **Nutrition and Exercise consulting**

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PATIENT FINANCIAL & CANCELLATION POLICY

PAYMENT METHODS & BILLING: Gervaise Gerstner, M.D. Dermatology is fee for service only. Payment is due at the time of service. We accept Cash, Checks, MasterCard, Visa, American Express and Discover for your convenience. If at any time you have any questions about the cost of a procedure proposed by Dr. Gervaise Gerstner, we will be happy to discuss the cost with you.

INSURANCE: Gervaise Gerstner, M.D. Dermatology does not participate with any medical insurance plans including Medicare. However, patients will be given the required forms to submit to their insurance provider to receive a reimbursement. For questions about insurance coverage, please contact your insurance provider directly.

CANCELLATIONS: Please provide 24 hours' notice if you wish to reschedule or cancel your appointment. Cancellations made with less than the required notice are subject to a 50% charge of the scheduled procedure. If your appointment is on a Monday, please contact our office to reschedule or cancel your appointment by midday on the Friday prior to your appointment. Note: Coolsculpt, Fraxel and Laser hair removal require 48 hours' notice.

LATE APPOINTMENTS: Patients arriving fifteen minutes late for their appointment will be subjected to a shorter appointment or required to pay a late fee in order to extend their appointment. Patients arriving thirty minutes late will result in a late fee charge with the option of waiting for the next available appointment.

PRODUCT RETURNS & REFUNDS: Unopened items purchased may be returned within 10 days of your original purchase date for a refund, exchange or credit.

I, _____ have read, understand and agree to the above Patient & Financial and Cancellation Policy of Gervaise Gerstner, M.D.

Date _____

I authorize Gervaise Gerstner, M.D. Dermatology to charge my credit card kept on file for any unpaid, cancellation and/or late fees.

Patient/Guardian signature _____

Date _____

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Authorization for Payment by Credit Card

Account Type: ☐ **VISA** ☐ **MASTERCARD** ☐ **AMEX** ☐ **DISCOVER**

_____
Cardholder Name

_____ _____/_____
Credit Card Number **Expiration Date (mm/yy)**

VIN # (in signature strip on back of card or front for AMEX) _____

_____ _____
Signature of Cardholder **Date**

_____
Billing Address (including zip code) for credit card <u>if different from patient's residence</u>