How Did You Hear About Us? ***(Check One)***

☐ Friends/Family
☐ Previous Patient
☐ Walk-in
☐ Online/Google
☐ Insurance
☐ Other (Specify): _____

Patient Information

- **Full Name:** _____
- **Date of Birth** (MM/DD/YYYY) ____/_____/_____
- **Social Security Number:** ___ ___ ___
- **Gender:** ☐ Male ☐ Female ☐ Other
- **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Race & Ethnicity ***(Check All That Apply)***

- **Race:** ☐ White ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ Other: _____
- **Ethnicity:** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Contact Information

- **Home Phone:** _____
- **Cell Phone:** _____
- **Can We Leave a Detailed Message?** ☐ Yes ☐ No
- **Email:** _____
- **Home Address:** _____ _____

Pharmacy Information

- **Pharmacy Name:** _____
- **Pharmacy Address:** _____
- **Pharmacy Phone:** _____

Substance Use History

- **IV Drug Use:** ☐ Yes ☐ No
- **Alcohol Use:** ☐ Yes ☐ No
  - **Men:** 5+ drinks/day
  - **Women:** 4+ drinks/day

Emergency Contact

- **Name:** _____
- **Relationship:** _____
- **Phone:** _____
- **Do you give consent for us to speak to this person about your care?** ☐ Yes ☐ No

Medical History *(Check All That Apply)*

☐ Stents ☐ Organ Transplant ☐ Heart Murmur ☐ MVP
☐ Anxiety ☐ Hearing Loss ☐ Arthritis ☐ Hepatitis
☐ Asthma ☐ Hypertension ☐ Atrial Fibrillation ☐ HIV/AIDS
☐ High Cholesterol ☐ Bone Marrow Transplant ☐ Hyperthyroidism
☐ Breast Cancer ☐ Hypothyroidism ☐ Colon Cancer
☐ Leukemia ☐ COPD ☐ Prostate Cancer
☐ Coronary Artery Disease ☐ Radiation Treatment
☐ Depression ☐ Seizures ☐ Diabetes ☐ Stroke
☐ End-Stage Renal Disease ☐ GERD
☐ Other: _____

Surgical History *(List All Prior Surgeries)*

_____

Skin Disease History *(Check All That Apply)*

☐ Acne ☐ Actinic Keratosis ☐ Basal Cell Carcinoma ☐ Squamous Cell Carcinoma
☐ Melanoma ☐ Blistering Sunburn ☐ Precancerous Moles ☐ Psoriasis
☐ Eczema ☐ Other: _____

Sun Exposure & Protection

- **Do you wear sunscreen?** ☐ Yes (SPF: ____) ☐ No
- **Do you use tanning beds?** ☐ Yes ☐ No

Family History of Melanoma

☐ Yes (Relative: ☐ Mother ☐ Father ☐ Sibling ☐ Other: _____) ☐ No

Medications & Allergies

- **Current Medications:** *(List or provide to front desk)*
- **Allergies to Medications?** ☐ Yes (Specify: _____) ☐ No

_____
_____

For Female Patients Only

- **Last Menstrual Period:** ____/_____/_____
- **Menopausal:** ☐ Yes ☐ No

Smoking History ***(Check One)***

☐ Current Smoker ☐ Former Smoker ☐ Never Smoked

Medical Considerations ***(Check Yes or No)***

Medical Condition	Yes	No
Pacemaker	☐	☐
Defibrillator	☐	☐
Premedication for Procedures	☐	☐
Allergy to Adhesive	☐	☐
Blood Thinners	☐	☐
Pregnancy/Planning Pregnancy	☐	☐
Allergy to Lidocaine	☐	☐
Dental Anesthesia Issues	☐	☐
Artificial Joints (Last 2 Yrs)	☐	☐
Artificial Heart Valve	☐	☐

Reason for Today's Visit

Consent for Electronic Updates

- **Do you consent to electronically update your medication list?** ☐ Yes ☐ No
- **Do you consent to update your patient portal?** ☐ Yes ☐ No

Primary Care Physician (PCP)

- **Name:** _____
- **Phone:** _____

VIDA DERMATOLOGY
LARISSA LOBATO, APN
759 BROAD ST SUITE 104
SHREWSBURY, NJ 07702
Tel 732-307-3834
Fax 888-2590745

NO SHOW/ CANCEL POLICY

All no shows and patients who cancel their appointments without 24 hours notice will be charged a fee of $50

(Please initial) _____

Our office will call you to confirm one business day before your appointment time. Please be aware that your APPOINTMENT will be cancelled if it is NOT CONFIRMED by you

(Please initial) _____

Name _____

Sign _____

Date ___/___/_____

VIDA DERMATOLOGY
LARISSA LOBATO, APN
759 BROAD ST SUITE 104
SHREWSBURY, NJ 07702
Tel 732-307-3834

Patient or POA: _____

Please be advised, although your insurance company has authorized services, this is not a guarantee of payment. If your insurance company denies those services, you will be responsible for payment. (Please initial) _____

I have been advised that if Vida Dermatology does not accept my secundary insurance I will be responsible for any remaining balance after my primary insurance.
(Please initial) _____

It is my responsibility to obtain a referral if it is required by my insurance. If I fail to provide a valid referral at the time of service and my insurance denies my bills for lacking referrals/authorization, I will be responsible for payment in full to Vida Dermatology. (Please initial) _____

I have been advised that Vida Dermatology sends all specimens to labs of practice choice. If patient's insurance is associated with specific lab(s), it is patient's responsibility to inform Vida Dermatology of their lab(s) before the appointment.
(Please initial) _____

Print name of patient or POA _____
Patient or POA Signature _____
Date ____/____/_____

Patient Consent for Use and Disclosure of Protected Health Information

I hear by give my consent for Larissa Lobato, APN to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Larissa Lobato, APN's Notice of Privacy Practices provides a more complete description of such uses and disclosures)

I have the right to review the Notice of Privacy Practices prior to signing this consent. The practice reserves the right to revise its Notice of Privacy Practices at Larissa Lobato APN at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Larissa Lobato, APN. Privacy Officer at

Larissa Lobato, APN
750 Broad St Suite 104
Shrewsbury NJ 07702

With this consent, Larissa Lobato, APN may call my home, cell or other phone number listed on my chart and leave a message on voicemail or in person in reference to any item that assist the practice in carrying out TPO such as appointment reminders, insurance items and anything pertaining to my medical care, including laboratory test results and others.

With this consent, Larissa Lobato APN may mail to my home or other alternative location listed on my chart any item that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent Larissa Lobato APN may email me any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements. I have the right to request that Larissa Lobato APN restrict how it uses or discloses my PHI to TPO. However, the practice is not required to agree to my requested restrictions, it is bound by this agreement.

By signing this form, I am consenting to Larissa Lobato APN use and disclosure of my PHI to Carry out my TPO.

I understand that I may revoke my consent in writing at any time, except to the extent that Larissa Lobato APN has already acted in reliance on this consent.

Signature of patient or legal Guardian _____

Print name of patient or legal Guardian _____

Date _____/_____/_____