Office Use:
Carecloud:____
EMA:____

Connecticut Skin Institute
Patient Registration Form

Patient Information:

Last Name:_____ First Name:_____ MI:_____ □ Mr. □ Ms. □ Mrs. □ Dr.

Home Address:_____ City:_____ State:_____ Zip:_____

Home Phone #:_____ Work Phone #:_____ Cell Phone #:_____ Email:_____

Sex: □M □F Birthdate:_____ Race:_____ Preferred Language:_____

Place of Birth: _____ Place of Employment:_____ Occupation:_____

Preferred method of contact:_____ Can we leave detailed message: □ yes □ no

Primary Care Doctor:_____ City:_____ State:_____

Referring Doctor:_____ City:_____ State:_____

Emergency Contact:_____ Relationship:_____ Phone #:_____

How did you hear about us? □ Doctor □ Existing patient □ Online _____ □ Magazine: _____ □Other:_____

If you provided us with an email, we will email you updates from Dr. Omar Ibrahimi (at most 1 time a month). You can opt-out at any time by clicking "unsubscribe" at the bottom of any email or by notifying the front desk.

Primary Insurance Name:_____ Subscriber Name:_____

Relation to Patient: □ Self □ Spouse □ Dependent Birthdate:_____

Notice of Privacy Practices: (If the patient is a minor, guardian signature required)

A Notice of Privacy Practices has been provided to me by CT Skin Institute.
(A copy is located at our front desk for your convenience)

_____ _____
Your Signature **Today's Date**

Do you give our office permission to discuss your medical information with family member(s) ____Yes ____No

Name:_____ Relationship: _____ Phone #: _____

Authorization of Assignment and Release:
I authorize payment of Medicare **and/or** other insurance benefits be made on my behalf to Connecticut Skin Institute for any services furnished to me by Connecticut Skin Institute. I authorize release of any information needed to determine these benefits or benefits payable for related services.

_____ _____
Your Signature **Today's Date**

Financial Agreement

- I certify that the insurance information I have provided is accurate. I will be responsible for all co-payments, deductible amounts and past balances at the time of service. Payments can be made in the form of cash, check or debit/mastercard/visa/discover.
- I understand that statement balances are due within 30 days of receipt. I understand that if the office has to MAIL more than one statement, there is a charge of $5 for each additional statement and there is a $15 charge for any copays not paid at time of service.
- In the event of a bounced check, I agree to pay a $50 fee for each returned or NSF check. In the event of a credit card chargeback, I agree I am responsible for any fees/penalties associated with the chargeback.
- In the event of default: my account will be forwarded to a collection agency. Should collection proceedings or other legal actions become necessary to collect an overdue account, I agree to pay all costs including but not limited to collection fees, court costs, and attorney fees.
- **I understand that for appointments (excluding procedures) not cancelled at least ONE business day prior to scheduled time will be subject to a $75.00 fee (for example, for a Monday 8 AM appointment, must call by Friday at 8 AM).**
- **I understand:**
    - **for any scheduled procedures (i.e. laser, surgery, devices, etc) there will be a $200 NONREFUNDABLE deposit required. I understand if I reschedule with less than 3 business days or NO SHOW, I will lose the deposit.**
    - **If the procedure is going through insurance, I will be subject to a $200 cancellation fee for cancelling with less than 3 business day notice.**

For any same day cancellations, I understand I will owe 50% of the total amount for procedure. We understand emergencies come up and therefore the office will allow one courtesy cancellation per person at no charge (courtesy does not apply to no shows).

_____ _____
Your Signature **Today's Date**

Connecticut Skin Institute
History and Intake Form

Name: _____ **Date of Birth:** _____

Past Medical History (Please check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial joints
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ BPH
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Pacemaker
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Valve Replacement
- ☐ **None**

Other _____

Past Surgical History (Please check all that apply)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy (Right, Left, Bilateral)
- ☐ Lumpectomy (Right, Left, Bilateral)
- ☐ Breast Biopsy (Right, Left, Bilateral)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ PTCA
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement, Knee (Right, Left, Bilateral)
- ☐ Joint Replacement, Hip (Right, Left, Bilateral)
- ☐ Joint Replacement within last 2 years
- ☐ Kidney Biopsy
- ☐ Kidney Removed (Right, Left)
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP
- ☐ Skin Biopsy
- ☐ Basal Cell Cancer Surgery
- ☐ Squamous Cell Carcinoma Surgery
- ☐ Melanoma Surgery
- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Bilateral)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ **None**

Other _____

Pharmacy: we must keep a pharmacy on file

Name: _____

Address: _____

_____

_____

Phone: _____

Connecticut Skin Institute
History and Intake Form

Name: _____ **Date of Birth:** _____

Skin Disease History (Please check all that apply)

- □ Acne
- □ Actinic Keratoses
- □ Asthma
- □ Basal Cell Skin Cancer
- □ Blistering Sunburns
- □ Dry Skin
- □ Eczema
- □ Flaking or Itchy Scalp
- □ Hay Fever/Allergies
- □ Melanoma
- □ Poison Ivy
- □ Precancerous Moles
- □ Psoriasis
- □ Squamous Cell Skin Cancer
- □ **None**

Other _____

Do you wear Sunscreen? □ Yes □ No If yes, what SPF? _____
Do you tan in a tanning salon? □ Yes □ No
Do you have a family history of Melanoma? □Yes No If yes, which relative(s)? _____

Any other family history: _____

Medications (Please enter all current medications with doses, frequency and route of intake)

_____
_____
_____
_____

Allergies (Please enter all allergies including drug allergies)

_____
_____
_____
_____

Social History (Please check all that apply)

Cigarette Smoking:
Never smoked
Quit: former smoker
Smokes less than daily
Smokes daily

Illicit Drug Use:
Drug Use
IV Drug Use

Sexual History: (OPTIONAL to answer)
Not sexually active
Sexually active with more than one partner
Sexually active with same gender partner
Sexually active with one partner

Alcohol Use:
Alcohol: none
Alcohol: less than 1 drink a day
Alcohol: 1-2 drinks a day
Alcohol: 3 or more drinks a day

Safety:
I feel safe at home.
I do not feel safe at home.

Connecticut Skin Institute
Review of Systems Form

Name: _____ **Date of Birth:** _____

Please tick any of the below issues that apply to you

- ☐ Problems with bleeding (Hematologic / Lymphatic)
- ☐ Problems with healing (Integumentary)
- ☐ Issues with scarring (hypertrophic or keloid/Integumentary)
- ☐ Rash (Integumentary)
- ☐ Immunosuppression (Allergic / Immunologic)
- ☐ Hay fever (Allergic / Immunologic)
- ☐ Chest pain (Cardiovascular)
- ☐ Fever or chills (Constitutional / Symptom)
- ☐ Night sweats (Constitutional / Symptom)
- ☐ Unintentional weight loss (Constitutional / Symptom)
- ☐ Thyroid problems (Endocrine)
- ☐ Sore throat (ENT and Mouth)
- ☐ Blurry vision (Eyes)
- ☐ Abdominal pain (Gastrointestinal (G.I.))
- ☐ Bloody stool (Gastrointestinal (G.I.))
- ☐ Bloody urine (Genitourinary (G.U.))
- ☐ Joint aches (Musculoskeletal)
- ☐ Muscle weakness (Musculoskeletal)
- ☐ Neck stiffness (Musculoskeletal)
- ☐ Headaches (Neurological)
- ☐ Seizures (Neurological)
- ☐ Cough (Respiratory)
- ☐ Shortness of breath (Respiratory)
- ☐ Wheezing (Respiratory)
- ☐ Anxiety(Psychiatric)
- ☐ Depression (Psychiatric)

- ☐ **None**

List Any Other Problems: _____
_____
_____

Alerts (Tick any of the below that you have issues with)

- ☐ Allergy to adhesive
- ☐ Allergy to lidocaine
- ☐ Allergy to topical antibiotic ointments
- ☐ Artificial heart valve
- ☐ Artificial joints within past two years
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ History of MRSA
- ☐ Pacemaker
- ☐ Premedication prior to procedures
- ☐ Rapid heartbeat with epinephrine
- ☐ Pregnancy or planning a pregnancy

Connecticut Skin Institute
PATIENT E-MAIL CONSENT FORM

*Patient E-mail (please print clearly):

*Patient Name:

*Patient DOB:

Items with * required

Provider: Dr. Omar Ibrahimi

Provider E-mail: @ctskindoc.com*

*Uncrypted email is not a secure form of communication. We will use the minimum necessary amount of protected health information in any communication.

1. RISK OF USING E-MAIL

Transmitting patient information by E-mail has a number of risks that patients should consider. These include, but are not limited to, the following:

a) E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b) E-mail senders can easily misaddress an E-mail.
c) Backup copies of E-mail may exist even after the sender or the recipient has deleted his or her copy.
d) Employers and on-line services have a right to inspect E-mail transmitted through their systems.
e) E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
f) E-mail can be used to introduce viruses into computer systems.

2. CONDITIONS FOR THE USE OF E-MAIL

The Provider cannot guarantee but will use reasonable means to maintain security and confidentiality of E-mail information sent and received. The Patient and Provider must consent to the following conditions:

a) E-mail is not appropriate for urgent or emergency situations. The Provider cannot guarantee that any particular E-mail will be read or responded to.
b) E-mail must be concise. The Patient should schedule an appointment if the issue is too complex or sensitive to discuss via E-mail.
c) E-mail communications between patient and provider will be filed in the Patient's permanent medical record or departmental file.
d) The Patient's messages may also be delegated to another provider or staff member for response. Office staff may also receive and read or respond to patient messages.
e) The Provider will not forward patient-identifiable E-mails outside of CT Skin Institute without the Patient's prior written consent, except as authorized or required by law.
f) The Patient should not use E-mail for communication regarding sensitive medical or financial information (i.e. credit card numbers),
g) It is the Patient's responsibility to follow up and/or schedule an appointment if warranted.
h) Recommended uses of patient-to-provider e-mail should be limited to:
   a. Appointment requests
   b. Appointment confirmations
   c. Requests for information
   d. Non-urgent health care questions
   e. Updates to information or exchange of non-critical information such as routine laboratory values, immunizations, insurance changes, financial eligibility information, financial statements.

3. INSTRUCTIONS

To communicate by E-mail, the Patient shall:

a) Avoid use of his/her employer's computer.
b) Put the Patient's name in the body of the E-mail.
c) Put the topic (e.g., medical question, billing question) in the subject line.
d) Inform the Provider of changes in the Patient's E-mail address.
e) Take precautions to preserve the confidentiality of E-mail and any attached documents.
f) Contact the Provider's office via conventional communication methods (phone, , etc.) if the patient does not receive a reply within a reasonable period of time.

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of E-mail between the Provider and me. I consent to the conditions and instructions outlined here, as well as any other instructions that the Provider may impose to communicate with me by E-mail. I agree to use only the pre-designated e-mail address specified above. Any questions I may have had were answered. The Provider will mostly only make initial outreach to me with patient statements or appointment reminders.

Patient Signature:_____Date

Original – to be retained in Medical Record

Connecticut Skin Institute
Skin Cancer Laser & Cosmetic Surgery

Cosmetic Interest Questionnaire

Name:

Comments:

These are the areas of concern for me:

- ☐ Fine Lines and wrinkles
- ☐ Wrinkles / Lines around nose and mouth
- ☐ Length / Thickness of eyelashes
- ☐ Texture of skin / Pore Size
- ☐ Facial Veins
- ☐ Spider Vein Treatment
- ☐ Age Spots / Liver Spots (skin blemishes)
- ☐ Birthmarks
- ☐ Skin Pigmentation
- ☐ Acne Scars or other scars
- ☐ Unwanted Hair (Facial or Body)
- ☐ Dark circles under eyes
- ☐ Freckles / Sun Damage
- ☐ Loose Skin/Skin Tightening
- ☐ Other_____

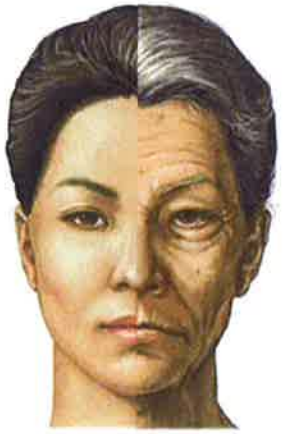
These are treatments I am interested in:

- ☐ Ultherapy
- ☐ Sculptura
- ☐ Botox
- ☐ Fillers
- ☐ Latisse
- ☐ Tattoo Removal
- ☐ Injectables
- ☐ Body Contouring/ Non-invasive Coolsculpting
- ☐ Rejuvenation
- ☐ Facials and eye treatments
- ☐ Skin Care Products

Ranking of concerns:

1.
2.
3.
4.
5.
6.
7.

Please feel free to mark areas of concern on facial diagram.



Other Comments:

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		*True Age*		*Older Than*
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

Signature: