# MOHS PATIENT INFORMATION

*(Please Print or Complete On-Screen)*

Today's Date: _____

Name _____
*Last* *First* *Middle Initial*

Mailing Address _____
*Street*

_____
*City* *State* *Zip*

Home Phone _____ Business Phone _____

★ **Referring / Primary doctor:** _____

## PRIMARY INSURANCE

Subscriber's Name: _____

Relationship to patient _____

Policy # _____ Birth date _____

Health Insurance Co.: _____

Group # _____

## SECONDARY INSURANCE

Subscriber's Name: _____

Relationship to patient _____

Policy # _____ Birth date _____

Health Insurance Co.: _____

Group # _____

Please list any medications you are ALLERGIC or SENSITIVE to: _____

Please list all MEDICATIONS you currently take (including any over-the-counter medications): _____

When was your last aspirin? _____

Please list your MEDICAL PROBLEMS or conditions: _____

Please list your PREVIOUS SURGERIES: _____

Have you ever had:

| | | |
|---|---|---|
| Hepatitis: | ◯ Yes | ◯ No |
| Endocarditis: | ◯ Yes | ◯ No |
| Radiation or x-ray treatments: | ◯ Yes | ◯ No |
| Skin Cancer: | ◯ Yes | ◯ No |

If yes, what type and when: _____

Do you have:

| | | |
|---|---|---|
| Artificial joint: | ◯ Yes | ◯ No |
| Artificial heart valve: | ◯ Yes | ◯ No |
| Pacemaker: | ◯ Yes | ◯ No |
| Bleeding condition: | ◯ Yes | ◯ No |

Do you smoke? ◯ Yes ◯ No Do you drink alcohol? ☐ Never ☐ Occasionally ☐ Frequently

Do you have a family history of Skin Cancer? ◯ Yes ◯ No If yes, explain: _____

Is your weight stable? ◯ Yes ◯ No Is your energy good? ◯ Yes ◯ No Is your general health good? ◯ Yes ◯ No

What is the problem for which you are being seen? _____

How long have you had your current problem? _____

Where on your body is your current problem? _____

Has your current problem ever been treated before? If yes, explain: _____

How does your current problem bother you? Itch, painful, bleeds, other: _____

# Center for Laser and Dermatologic Surgery

*Yehuda D. Eliezri, M.D.*
*Edward B. Desciak, M.D.*
*7A Medical Park Drive*
*Pomona, NY 10970*
*(845) 354-1169*


## For Insured's or Authorized Person's Signature

I authorize the release of any medical or other information necessary to process this claim to my insurance company.

_____

I authorize payment of medical benefits and/or government benefits to Yehuda D. Eliezri, M.D. / Edward B. Desciak, M.D. for services rendered.

_____

I have been notified that should it become necessary to send any outstanding balances to a collection agency, the patient will be responsible for any fees incurred by this office.

_____

IF the Doctors ***DO NOT*** participate in your health insurance plan, please sign.

I have been notified that Dr. Eliezri and Dr. Desciak do not participate in my health insurance plan.
I understand that I am responsible for any fees that are incurred at this office.

_____