1260 Broadcasting Road
Wyomissing, PA 19610

ADVANCED SKIN CARE
HARRIET COMITE MD

T 610.374.1400 **F** 610.374.1828
www.ComiteSkin.com

Health History

Name: _____ **Date:** _____
Last First Middle Initial

1) Who referred you to Dr. Comite? _____
Dr's Name, Friend, Family, Yellow Pages, Web, Magazine, Other [Please Specify]

2) Briefly describe your skin problem: _____
_____

Current Treatment: _____
_____

Past Treatment: _____
_____

3) Are you taking any medications for any reason? If yes, please specify

___ Antacids
___ Antibiotics
___ Antihistamines
___ Antidepressants
___ Aspirin, Bufferin, Advil, etc.
___ Birth Control Pills
___ Blood Thinner
___ Blood Pressure Pills
___ Cortisone/Steroids
___ Cough Medicine
___ Digitalis
___ Dilantin
___ Hormones
___ Insulin/Diabetic
___ Iron Poor Medication
___ Laxatives
___ Injections
___ Sleeping Medication
___ Thyroid Medication
___ Tranquilizers
___ Vitamins
___ Water Pills
___ Weight Reduction
___ Other Non-prescription Rx:
_____
_____

___ I DO NOT TAKE ANY MEDICINES

4) Are you allergic to ANY MEDICINE? Please specify, including reaction:
_____

5) Do you have any other allergies? Please specify
_____

6) Operations/Surgeries you have had (include year):
_____

7) Disease you have had requiring hospitalization (include year):
_____

8) Any serious illnesses NOT REQUIRING HOSPITALIZATION?
_____

9) Do you see any other type of doctor or specialist {i.e. Cardiologist, Allergist, Gynecologist, etc.}
Please specify names of Doctors:
_____

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Patient Information

Patient Name: _____ _____ _____
Last First Middle Initial

Date of Birth: _____ ____ _____ _____ Male _____ Female ____ Minor
Month Date Year

Social Sec #_____-_____-_____ Marital Status: Single Married Widow Div Partner

Home Address: _____ _____ _____ _____ _____
#/ RR# Street City State Zip Code

Telephone Numbers: Home (_____)_____ Cell (_____)_____

Work (_____)_____ _____ Other (_____)_____
Ext #

I give my permission to leave detailed messages on my phone Y • N Home/ Cell/ Work/ Other

E-mail Address: _____
Providing your email address gives permission for us to send discount offers and informational emails.

Employer: _____ _____ _____
Name Address Occupation/ Job Title

Name of Family Doctor: _____ Phone:_____

1. **Primary** Ins Co: _____ Subscriber: _____
Name DOB

Insurance ID (Policy #): _____ Group #: _____

2. **Secondary** Ins Co: _____ Subscriber: _____
Name DOB

Insurance ID (Policy #): _____ Group #: _____

Responsible Person: _____ Relationship to Patient: _____
(If under age 18) Last First Middle Initial (Please specify)

Address (If different from above): _____ _____ _____ _____ _____
#/ RR# Street City State Zip Code

Telephone Numbers: Home (_____)_____ Cell (_____)_____
(If different from above)

Work (_____)_____ _____ Other (_____)_____
Ext #

Name Phone #

Patient or Guardian Signature: _____ Date: _____

(Rev 4/20/12)

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Cancellation & Missed Appointment Policy

Our office considers an appointment to be a commitment and an agreement. When an appointment is scheduled, the doctor and staff time is set aside for you. Unlike other practices, we do not double or triple book patients. Therefore, we must charge a fee for all appointments not cancelled two weeks in advance.

In today's busy world, unplanned issues arise for all of us. However, we politely request that appointments, which you are unable to honor, are appropriately cancelled so that we may offer them to a patient on our waiting list.

Cancelled Appointments:	No charge will be made for any appointment cancelled at least two weeks in advance.
Missed Appointments:	A missed or cancelled medical appointment without two weeks notice will be billed a fee of $50.00. A missed or cancelled cosmetic appointment without two weeks notice will be billed a fee of $200.00.
Exceptions:	Same day cancellation because of serious medical/family emergency or dangerous road conditions (snow and ice) will not be charged as long as we are notified by telephone before the scheduled appointment time.

I am aware of the Cancellation & Missed Appointment Policy and agree to the terms.

_____ _____

Signature Date

_____

Parent or Guardian of Patient if less than 18 years of age

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Letter of Authorization

I hereby request and authorize HARRIET COMITE, MD and/or her staff to administer such drugs and treatments and/or perform such dermatological surgical procedures as are deemed necessary by the doctor or designated staff.

I authorize HARRIET COMITE, MD and/or her staff to take pertinent photographs and I consent to their use for medical purposes.

I have been advised and I do fully understand that although good results are expected by patient and physician alike, results cannot be, and are not, guaranteed; nor can there be any guarantee against untoward results.

PATIENT'S NAME: _____
Please Print

PATIENT'S SIGNATURE: _____

PARENT/LEGAL GUARDIAN SIGNATURE {If patient is under 18 years of age}:

_____

_____ _____
Witness Date

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Authorization To Release Information

I hereby authorize Harriet Comite, MD PC to release medical or other incidental information that may be necessary for my treatment and medical care or for the processing of medical claims, applications and financial benefits on my behalf. This Authorization will remain in effect from this date unless retracted in writing by me.

_____ _____
Signature of patient or responsible person Date

Awareness of Non-Participation

I am aware that Harriet Comite MD PC is a non-participating provider with Medicare, Medicare Supplemental, Medigap, or any Commercial Insurance Plans.

There will be charges for which I am responsible.

_____ _____
Signature of patient or responsible person Date

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Preferred Pharmacy

Patient Name: _____ Today's Date: _____

○ **CVS Pharm** □ 544 Penn St 610.376.2729 □ 1303 Lancaster Ave 610.796.3103 □ 2001 N. 11th St 610.921.1200 □ 3498 N 5th St 610.929.9864

□ 3100 Shillington Rd 610.678.9054 □ 103 Lancaster Pike 610.777.4760 □ 906 W Leesport Rd 610.208.8612 □ 8565 Allentown Pike 610.916.2499

□ 1054 Shoemaker Ave 610.562.2454 □ Douglassville 610.385.4300 ○ **Esterbrooks Pharm** □ 301 S 7th Ave 610.376.6542

○ **Giant Pharm** □ 4655 Perkiomen Ave 610.406.9644 □ 4320 N 5th St Hwy 610.939.2644 □ 2641 Shillington Rd 610.678.3335 □ 600 E Lancaster Ave 610.777.0027

□ 2104 Van Reed Rd 610.670.5426

○ **Medicine Shoppe** □ 1170 Perkiomen Ave 610-378-1396 ○ **Redners Pharm** □ 5471 Pottsville Pike 610-926-6660

○ **Rite Aid Pharm** □ 524 N 6th St 610.374.6282 □ 418 Penn St 610.373.4511 □ 500 E Lancaster Ave 610.775.0307 □ 525 Penn Ave 610.373.5241

□ 2962 St Lawrence Ave 610.779.3120 □ 670 Philadelphia Ave 610.777.8278 □ 3215 5th St Hwy 610.929.9775 □ 2210 State Hill Rd 610.378.1465

□ 807 S 4th St 610.562.9454 □ 2320 Penn Ave 610.678.2909 □ 4810 Penn Ave 610.670.9986 □ 4280 Perkiomen Ave 610.779.3266 □ 5370 Allentown Pike 610.929.1367

○ **Sam's Club Pharm** □ 5314 Allentown Pike 610-929-5357

○ **Target Pharm** □ 4599 Perkiomen Ave 484.651.1921 □ 2769 Papermill Rd 610.374.9942 □ 4220 N 5th St Hwy 610.921.5140

○ **West Reading Drug** □ 538 Penn Ave 610.375.4366

○ **Wal-Mart Pharm** □ 1135 Berkshire Blvd 610.376.5911 □ 5900 Perkiomen Ave 610.582.7288 □ 5370 Allentown Pike 610.939.0616

* **Other:**

_____ Pharm Name _____ Location _____ Phone

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Patient Communication Permission

Patient Name _____ Date of Birth _____

Practice Name **Harriet Comite, MD PC**

As a patient in our practice, from time to time we may need to communicate with you when you are not in the office. To preserve your privacy, we would like for you to indicate your preferred method for us to communicate medical information to you, and to others involved in your care. Examples of medical information include your test results or appointment reminders, and are clinical in nature.

Without specific permission we will not release any of your medical information to another person. In some cases you may wish for another person to have access to your medical information. Can you please identify those individual(s) and their relationship to you (i.e., spouse, parent, son, daughter, etc.)

NAME	RELATIONSHIP
_____	_____
_____	_____

In the event that no one is available to answer your phone, we need your permission to leave certain types of information on your answering machine or via voice mail. Please indicate your preference by checking one or more of the boxes below.

☐ Do not leave any medical information on an answering machine or voice mail.

☐ I give permission to **Harriet Comite, MD PC** personnel to leave the following forms of information pertaining to me on my answering machine or voice mail at the number(s) listed below.

Phone Number (Home) _____ (Work)_____ (Cell)_____

Appointment Reminders	____Yes	_____No
Laboratory or Pathology Results	____Yes	_____No
Other_____	____Yes	_____No
Any and All Types of Communication	____Yes	_____No

I assume responsibility to inform the practice of changes in my phone number(s) or my preference.

Name _____ Signature _____ Date _____

ADVANCED SKIN CARE
HARRIET COMITE MD

Cosmetic Interest Questionnaire

Name: _____ Date: _____

I am ☐ not concerned ☐ somewhat concerned ☐ very concerned ☐ very concerned about the appearance of my skin.

What services would you like to learn about? (Please check all that apply)

☐ Facial Fine Lines/Wrinkles
☐ Thin Lips/Lines around Mouth
☐ Botox®/Xeomin®
☐ Dermal Fillers-Voluma®/Vollure®/Volbella®
☐ Facial Redness/Rosacia/Flushing/Veins
☐ Tattoo Removal
☐ Texture of Skin
☐ Eyelashes/Brows- Length Fullness Color
☐ Excessive Sweating of Underarms
☐ Non-Invasive Skin Tightening
☐ Urinary Incontinence
☐ Hair Removal
☐ Facial Folds
☐ Facial Sagging/Lack of Fullness
☐ Facials/Peels
☐ Age Spots/Red or Brown Spots
☐ Acne Scarring
☐ Blotchy Skin
☐ Skin Care Products
☐ Leg Veins
☐ Non-Invasive Body Contouring

☐ I am not interested in other services at this time.

Are you interested in receiving information about our *PATIENT LOYALTY PROGRAM* that can assist you on obtaining the procedure you desire at up to half the cost on all of our cosmetic procedures and 10% off products?

_____ YES _____ NO THANK YOU _____ALREADY A MEMBER

May we contact you with future specials and promotions? Yes/NO

☐ By Phone (H)_____(C)_____

☐ By Email _____

For in office use only:

_____Spoke with pt in office _____Called & spoke with pt _____Left Message