



1260 Broadcasting Road, Wyomissing, PA
T 610.374.1400 F 610.374.1400
ComiteSkin.com

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 (_____) _____
Name Ext # Phone #

Patient/Guardian Signature: _____ Date: _____



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 _____



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



**Medicare Insured Patients Please Sign
Authorization & Awareness Of Non-Participation Below**

I hereby authorize Harriet Comite, MD PC to release any medical or other incidental information that may be necessary for my treatment and medical care for the processing of my Medicare and Supplemental/Medigap insurance benefits plan on my behalf. I am aware that Harriet Comite MD PC does not participate with Medicare and that there will be charges for which I am responsible.

Signature of patient or responsible person

Date



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

- | | | |
|---|---|--|
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Digitalis | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Dilantin | <input type="checkbox"/> Water Pills |
| <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Hormones | <input type="checkbox"/> Weight Reduction |
| <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Insulin/Diabetic | <input type="checkbox"/> Other Non-prescription Rx: |
| <input type="checkbox"/> Aspirin, Bufferin, Advil, etc. | <input type="checkbox"/> Iron Poor Medication | _____ |
| <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Laxatives | _____ |
| <input type="checkbox"/> Blood Thinner | <input type="checkbox"/> Injections | <input type="checkbox"/> I DO NOT TAKE ANY MEDICINES |
| <input type="checkbox"/> Blood Pressure Pills | <input type="checkbox"/> Sleeping Medication | |
| <input type="checkbox"/> Cortisone/Steroids | <input type="checkbox"/> Thyroid Medication | |
| <input type="checkbox"/> Cough Medicine | <input type="checkbox"/> Tranquilizers | |

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: _____



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