

WELCOME TO BROWNSTONE DERMATOLOGY ASSOCIATES

Christine L. Cassel, M.D.
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Emily Quezada, CMA

We are pleased that you have chosen Brownstone Dermatology Associates to provide you with your dermatologic services. Please arrive 10 minutes early for your first appointment and bring your insurance cards. Please print and complete the "History Questionnaire" (see next page) and bring to your first visit if possible.

We will collect your co-payment at time of registration and bill your insurance company if you are covered by one of the insurance companies we participate with. Payment may be made in cash, check or credit card. For your convenience, we accept Visa, Discover, MasterCard and American Express.

We ask that you provide at least 24 hours advance notice to our office staff if you are not able to keep your appointment with us. There is a \$50.00 no-show fee for unattended appointments. There are many patients waiting for appointments and this has dramatically reduced their wait time.

Office Rules:

- Cell phone use is prohibited in office
- No pets allowed inside Brownstone Dermatology building, unless a service animal is required by the patient
- Please inform doctor at beginning of visit when a 90 day script will be needed
- A \$50.00 "No Show" fee for missed or late cancellation (less than 24 hours notice) appointments will be charged

Directions to our office:

From Harrisburg and West – take 322E – take the Hummelstown/Middletown exit. Turn left off exit and follow to square in Hummelstown. Turn right on Main Street and follow thru to fork in street and bear left onto Walton Avenue. Just past the post office, our office is on the left on the corner of Allison and Walton.

From Lebanon and East – take 322W – to Rt. 39 Hershey Park Drive exit. At first light, make a left onto Walton Avenue and proceed to top of the hill, our office is on the right at the corner of Allison and Walton.

From Lancaster – take 283W to Hummelstown/Middletown Vine Street exit. Turn right off of exit and follow to square in Hummelstown. Turn right on Main Street and follow thru to fork in street and bear left onto Walton Avenue. Just past the post office our office is on the left on the corner of Allison and Walton.

We look forward to meeting you, should any questions or issues arise before your scheduled appointment please contact our office at (717) 566-6633. Thank you.

Brownstone Dermatology Associates
530 Walton Ave.
Hummelstown, PA 17036

Patient Name _____
Date of birth _____
Phone _____

HISTORY QUESTIONNAIRE

Reason for visit _____ Who is your family doctor? _____

Email Address: _____

Pharmacy: Name _____ Location _____

MEDICATIONS: (Including over the counter)

- | | | |
|----|----|----|
| 1. | 4. | 7. |
| 2. | 5. | 8. |
| 3. | 6. | 9. |

MEDICATION ALLERGIES: YES NO

If Yes, Please list: _____

I give my consent to import my active medications list YES NO

Please check any of the following problems you have or have had:

<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Skin cancer
<input type="checkbox"/>	COPD/Emphysema	<input type="checkbox"/>	Other cancer
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Infectious disease such as HIV or Hepatitis
<input type="checkbox"/>	Liver problems	<input type="checkbox"/>	High cholesterol
<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	Antibiotics before dental procedures?

List any other medical problems? _____

What surgeries have you had? _____

Childhood History:

Family History:

<input type="checkbox"/>	Chickenpox	<input type="checkbox"/>	Eczema
<input type="checkbox"/>	Chickenpox shot	<input type="checkbox"/>	Hayfever/Asthma
<input type="checkbox"/>	Measles	<input type="checkbox"/>	Psoriasis
<input type="checkbox"/>		<input type="checkbox"/>	Melanoma
<input type="checkbox"/>		<input type="checkbox"/>	Other Skin Cancer
<input type="checkbox"/>		<input type="checkbox"/>	Other Cancer

Review of Symptoms (which of these have you recently had):

<input type="checkbox"/>	Fever	<input type="checkbox"/>	Food allergies	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	Chills	<input type="checkbox"/>	Runny nose	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	Weight loss	<input type="checkbox"/>	Cough	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Nightsweats	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Tingling
<input type="checkbox"/>	Easy bleeding	<input type="checkbox"/>	Clotting problems	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Muscle pain
<input type="checkbox"/>	Easy bruising	<input type="checkbox"/>	Excess thirst	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	Thyroid problems

Are you pregnant? YES NO Menstral Periods Regular? YES NO

Social history: Occupation _____

Do you smoke?	NO	YES	QUIT	_____	pks/day
Do you drink alcohol?	NO	Rarely	1/day	Frequently	
Do you consume caffeine?	NO	1-2/day	3+/day		
Are you sexually active?	NO	YES			

I have reviewed the Welcome Letter. Signature _____