

1260 Broadcasting Road
Wyomissing, PA 19610



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

- | | | |
|---|---|--|
| <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"/> Blood Pressure Pills | <input type="checkbox"/> Sleeping Medication | |
| <input type="checkbox"/> Cortisone/Steroids | <input type="checkbox"/> Thyroid Medication | <input type="checkbox"/> I DO NOT TAKE ANY MEDICINES |
| <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:

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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 (_____) _____
Name Ext # Phone #

Patient or Guardian Signature: _____ Date: _____

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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 1303 Lancaster Ave 2001 N. 11th St 3498 N 5th St
610.376.2729 610.796.3103 610.921.1200 610.929.9864
- 3100 Shillington Rd 103 Lancaster Pike 906 W Leesport Rd 8565 Allentown Pike
610.678.9054 610.777.4760 610.208.8612 610.916.2499
- 1054 Shoemaker Ave Douglassville ○ **Esterbrooks Pharm** 301 S 7th Ave
610.562.2454 610.385.4300 610.376.6542
- **Giant Pharm** 4655 Perkiomen Ave 4320 N 5th St Hwy 2641 Shillington Rd 600 E Lancaster Ave
610.406.9644 610.939.2644 610.678.3335 610.777.0027
- 2104 Van Reed Rd
610.670.5426
- **Medicine Shoppe** 1170 Perkiomen Ave ○ **Redners Pharm** 5471 Pottsville Pike
610-378-1396 610-926-6660
- **Rite Aid Pharm** 524 N 6th St 418 Penn St 500 E Lancaster Ave 525 Penn Ave
610.374.6282 610.373.4511 610.775.0307 610.373.5241
- 2962 St Lawrence Ave 670 Philadelphia Ave 3215 5th St Hwy 2210 State Hill Rd
610.779.3120 610.777.8278 610.929.9775 610.378.1465
- 807 S 4th St 2320 Penn Ave 4810 Penn Ave 4280 Perkiomen Ave 5370 Allentown Pike
610.562.9454 610.678.2909 610.670.9986 610.779.3266 610.929.1367
- **Sam's Club Pharm** 5314 Allentown Pike
610-929-5357
- **Target Pharm** 4599 Perkiomen Ave 2769 Papermill Rd 4220 N 5th St Hwy
484.651.1921 610.374.9942 610.921.5140
- **West Reading Drug** 538 Penn Ave
610.375.4366
- **Wal-Mart Pharm** 1135 Berkshire Blvd 5900 Perkiomen Ave 5370 Allentown Pike
610.376.5911 610.582.7288 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 _____



Cosmetic Interest Questionnaire

Name: _____

Date: _____

Phone: Home: _____

Alternative Phone: _____

Email : _____

Please Print Clearly

Please email me with special, promotions, events and other skin care information relevant to me.

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?

_____ YES _____ NO THANK YOU _____ ALREADY A LOYALTY MEMBER

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

- | | |
|--|--|
| <input type="checkbox"/> Facial Fine Lines/Wrinkles | <input type="checkbox"/> Hair Removal |
| <input type="checkbox"/> Thin Lips/Lines around Mouth | <input type="checkbox"/> Facial Folds |
| <input type="checkbox"/> Botox®/Xeomin® | <input type="checkbox"/> Facial Sagging/Lack of Fullness |
| <input type="checkbox"/> Juvederm®/Voluma®/Belotero®/Fillers | <input type="checkbox"/> Non-Invasive Skin Tightening |
| <input type="checkbox"/> Facial Redness/Rosacea/Flushing/Veins | <input type="checkbox"/> Acne Scarring |
| <input type="checkbox"/> Tattoo Removal | <input type="checkbox"/> Blotchy Skin |
| <input type="checkbox"/> Texture of Skin | <input type="checkbox"/> Excessive Sweating of Underarms |
| <input type="checkbox"/> Facials/Peels | <input type="checkbox"/> Make-up Application |
| <input type="checkbox"/> Eyelashes/Brows – Length Fullness Color | <input type="checkbox"/> Leg Veins |
| <input type="checkbox"/> Age Spots/Red or Brown Spots | <input type="checkbox"/> Skin Care Products |
- I am not interested in other services at this time.

For in office use only:

_____ Spoke with pt in office _____ Called & spoke with pt _____ Left message