

# HUNTERDON DERMATOLOGY, LLC

Christopher T. Cassetty, M.D.

6 North Main Street  
Flemington, NJ 08822

908-782-1647 phone  
908-782-7296 fax

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## MIPS Patient Intake Form

Patients of Hunterdon Dermatology, LLC,

Please help us continue to provide the best care we can, by assisting us with this form.  
Your cooperation is appreciated.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Do you have **any** of the following? Please **check** all that apply.

- Heart Failure
- Coronary Artery Disease (CAD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes

2. Do you have a PCP (Primary Care Physician)?

- Yes, I do have a PCP
  - PCP Name: \_\_\_\_\_
  - Month / Year of Last Visit: \_\_\_\_\_
- No, I do not have a PCP

3. Have you **ever** received the **pneumonia** vaccine? **Yes** or **No**

4. Did you receive the **flu** vaccine **this season**? **Yes** or **No**

5. Do you smoke? **Yes** or **No**

6. How many times in the last year have you had 4 or more alcoholic drinks **in one day**?

Please circle:            **1 OR LESS**            **2 OR MORE**

**Continued on back of page ...**

7. Do you have a healthcare proxy in the event you are unable to make your medical decisions?

**Yes, I do.**

● Designee's Name: \_\_\_\_\_

● Phone Number : \_\_\_\_\_

**No, I do not.**

8. Do you have a living will? **Yes** or **No**

9. IF YOU ANSWERED YES FOR QUESTION NUMBER 8, which statement best reflects your wishes on advanced care recommendations if something required a decision while in the office or on the property?

- Do not intubate: I do not** wish to have a breathing tube, even if it is necessary to save my life.
- Do not resuscitate:** If my heart were to stop, I **do not** wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is necessary to save my life.
- Full cardiopulmonary resuscitation:** I **do** want full cardiopulmonary resuscitation efforts to be made.

10. Do you have a history of cancer in your family?

**Yes, I do.** Please list the type below with your relationship to that person:

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**No, I do not.**