

# Manhasset Dermatology, P.C. Patient Registration Form

Name: \_\_\_\_\_  Jr  Sr  
*First MI Last*

Title:  Mr.  Mrs.  Ms.  Miss  Dr. Sex:  Male  Female

Date of Birth:      /      /      Social Security #: \_\_\_\_\_  
*M D Y*

Address: \_\_\_\_\_  
*Street # Street Name Apt #*  
\_\_\_\_\_  
*City State Zip*

Home Phone: ( ) \_\_\_\_\_ Alternate/Cell Phone #: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
*Name*

Referred By: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Pharmacy Telephone No.: \_\_\_\_\_

Please tell us how you learned about our office:  Yellow Pages  Insurance  Friend  Family  
 Other \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Date of Birth:      /      /       
*M D Y*

If Student:  Full Time  Part Time Name of School: \_\_\_\_\_

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. In order to establish optimal relations with our patients and avoid misunderstandings and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services or co-payments. In the event that your account must be turned over to collections, a \$10.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Do we have your permission to:

Leave a message on your answering machine at home?  Yes  No  
Leave a message at your place of employment?  Yes  No  
Discuss your medical condition with any member of your household?  Yes  No

If yes, with whom: \_\_\_\_\_ Relationship: \_\_\_\_\_

### We must be able to confirm your appointment.

Please indicate telephone number where we may do so. Telephone number: \_\_\_\_\_

**Insurance Information**

Primary Insurance Name: \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_

Patient's ID #: \_\_\_\_\_

Patient's ID #: \_\_\_\_\_

Group #: \_\_\_\_\_

Group #: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Patient's Relationship to Policy Holder: \_\_\_\_\_

Patient's Relationship to Policy Holder: \_\_\_\_\_

**Policy Holder Information (If Different from Patient)**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_

Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA)**

With my consent, Manhasset Dermatology, P.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Manhasset Dermatology, P.C.'s Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Manhasset Dermatology, P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Manhasset Dermatology, P.C.'s O.C. Privacy Officer. With my consent, Manhasset Dermatology P.C. may call my home or other designated location and leave a message on voice mail or in person in reference to any items and any call pertaining to my clinical care, including laboratory results among others. With my consent, Manhasset Dermatology P.C. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Manhasset Dermatology P.C.'s use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Manhasset Dermatology P.C. may decline to provide treatment to me.

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

**PATIENT CONSENT FOR RELEASE OF MEDICAL REPORTS**

I authorize Manhasset Dermatology, P.C. to release Laboratory reports, Pathology reports, and Consultation reports to Myself, Parent/Guardian, Referring and/or Primary Care Physician and/or Plastic Surgeons and other health care providers involved in my care.

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

**SIGNATURE ON FILE**

I authorize Manhasset Dermatology, P.C., to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents. I authorize release of any information related to any claims to all my insurance companies or other relevant parties. I understand that I am responsible for my bill and agree to pay all charges for services and items provided to me. I authorize my doctor to act as my agent in helping me obtain payments from my insurance companies. I authorize payment of health benefits otherwise payable to me, directly to my doctor. I permit a copy of this authorization to be used in place of the original.

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

# MEDICAL HISTORY

Patient's Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Are you allergic to any medications?  YES  NO If yes, please list:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

List all medications you are currently taking:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	YES	NO	Other Systemic:	YES	NO
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Stomach	<input type="checkbox"/>	<input type="checkbox"/>
			Bowel	<input type="checkbox"/>	<input type="checkbox"/>
			Hepatitis or Yellow Skin	<input type="checkbox"/>	<input type="checkbox"/>
			Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
			Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
			Convulsions, Epilepsy		
			or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
			Fainting	<input type="checkbox"/>	<input type="checkbox"/>
<b>Vascular:</b>					
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>			
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>			
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>			
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>			
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>			
Do you need pre-medication?	<input type="checkbox"/>	<input type="checkbox"/>			

Do you drink alcohol?  Yes  No If Yes \_\_\_\_\_ per day  
Do you use IV drugs?  Yes  No If Yes, what? \_\_\_\_\_ How much? \_\_\_\_\_  
Have you had or have you been exposed to HIV (AIDS)?  Yes  No  
Have you ever had dental anesthesia (Novocaine)?  Yes  No  
Any bad reaction?  Yes  No

**Skin:**  
When you are exposed to sun do you:  Tan only  Tan and burn  Burn  
Have you ever had skin cancer?  Yes  No If yes, where? \_\_\_\_\_  
Has anyone in your family had skin cancer?  Yes  No If yes, who? \_\_\_\_\_  
Do you have a history of any specific skin diseases?  Yes  No

If yes, please list: \_\_\_\_\_  
List any other disease or condition we should know about: \_\_\_\_\_  
List surgical procedures you have had in the last 6 months: \_\_\_\_\_

Please answer the following questions:

- A. Do you smoke?  Yes  No If yes, how much: \_\_\_\_\_  
B. Do you bleed easily?  Yes  No  
C. (Women) Are you pregnant?  Yes  No If yes, Due Date: \_\_\_\_\_  
D. Do you have artificial joint(s)?  Yes  No Do you need pre-meds?  Yes  No  
E. What is your occupation? \_\_\_\_\_  
F. What are your hobbies? \_\_\_\_\_

Completed by:  Patient  
 Medical Assistant

Initials

Signed by Physician

Date

Reviewed by

Date

