Long Island Medical & Cosmetic Dermatology, P.C.

REGISTRATION FORM

(Please Print)

Today's Date _____/_____/_____ Primary Care Physician_____

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Widow

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Social Security	Home Phone No. ( )

P.O. Box	City	State	ZIP Code

Occupation	Employer	Employer Phone No. ( )

Chose Office Because/Referred to Office by (Please check one box) ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Yellow Pages ❑ Zoc Doc ❑ Our Website-Shererdermatology.com ❑ Other

Other Family Members Seen Here _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Is this person a patient here?	❑ Yes ❑ No		

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co- $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Long Island Medical & Cosmetic Dermatology, P.C. or insurance company to release any information required to process my claims.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

PATIENT CELL PHONE NUMBER:_____ Your E-Mail Address:_____

MEDICAL HISTORY

Patient: _____ Date taken: _____

Reason for today's visit: _____

Are you allergic to any medications? ❑ Yes ❑ No If yes, list:

1. _____ 2. _____

List all Medications you are currently taking:

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

History of Diseases

Do you have now, or have you ever had diseases or conditions of:

Lungs:	Yes	No
Bronchitis	❑	❑
Emphysema	❑	❑
Asthma	❑	❑
Chronic Cough	❑	❑
Morning Cough	❑	❑
Vascular:		
High Blood Pressure	❑	❑
Chest Pain	❑	❑
Heart Attack	❑	❑
Heart Murmur	❑	❑
Irregular Heartbeat	❑	❑
Pacemaker	❑	❑
Phlebitis	❑	❑
Mitral Valve Prolapse	❑	❑

Other Systemic:	Yes	No
Diabetes	❑	❑
Thyroid	❑	❑
Kidney	❑	❑
Bladder	❑	❑
Stomach	❑	❑
Bowel	❑	❑
Hepatitis or Yellow Skin	❑	❑
Glaucoma	❑	❑
Arthritis/Joint Deformity	❑	❑
Convulsions, Epilepsy or Seizures	❑	❑
Fainting	❑	❑
Artificial Joints	❑	❑

Do you drink alcohol? ❑ Yes ❑ No If Yes, _____drinks per day

Do you use IV drugs? ❑ Yes ❑ No If Yes, what?_____How much? _____

Have you been or have you ever been exposed to any infections disease(s)? ❑ Yes ❑ No

Have you ever had dental anesthesia (Novacaine)? ❑ Yes ❑ No Any bad reaction? ❑ Yes ❑ No

Do you prophalax before dental procedures? ❑ Yes ❑ No

Do you have a latex allergy? ❑ 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

Has anyone in your family had skin cancer / melanoma? ❑ Yes ❑ No If yes, who?_____Type?_____

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: _____

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 Due Date: _____

D. What is your occupation? _____

E. What are your hobbies? _____

Completed by: ❑ Patient
❑ L.P.N. - R.N._____
Initials

Reviewed by: _____
Signed by Physician Date

Long Island Medical & Cosmetic Dermatology, P.C.

Patient Name_____ Today's Date____/____/____

Your Medical Doctor's Name

Last Name _____First Name _____ Phone_____

*Street Address*_____

City _____*State* _____*Zip Code*_____

Protected Health Information Release:

Concerning matters of my health, I give permission for Dr. Sherer or a member of his staff to speak with:

Name of person(s) _____relationship to patient _____

Name of person(s) _____ relationship to patient _____

I request that use and disclosure of the above described information be restricted in the following manner [description of restriction]:

_____

_____

Signature of patient: _____

Long Island Medical & Cosmetic Dermatology, P.C.

755 Park Avenue, Suite 500
Huntington, NY 11743
631.271.2769

400 South Oyster Bay Rd. Suite 200
Hicksville, N.Y. 11801
516.433.3200

COSMETIC INTEREST QUESTIONNAIRE

Patient Name: _____ Date: _____

Please answer the following questions so we can better address your concerns today:

If you could change one thing about your appearance, what would it be?

When looking in the mirror, I am concerned about the appearance of my wrinkles (circle one)

Yes *No*

Health issues and procedures or products of interest to you (please check all that apply).

- ❑ BOTOX® Cosmetic (Botulinum Toxin Type A)
- ❑ AHA and Glycolic Peels
- ❑ Collagen Therapy
- ❑ Skin Rejuvenation
- ❑ Avage™, Retin-A or Renova
- ❑ Micro-Dermabrasion
- ❑ Acne
- ❑ Chemical Peels
- ❑ Laser Resurfacing
- ❑ Laser Treatments
- ❑ Skin Care Advice
- ❑ Skin Care Products
- ❑ Birthmarks
- ❑ Liver Spots/Age Spots
- ❑ Sunscreen Advice
- ❑ Removing Leg Veins
- ❑ Facials and Eye Treatments
- ❑ Hair Removal
- ❑ Spider Vein Treatments
- ❑ Removing Facial Veins
- ❑ Other, please specify _____

_____
Patient Signature

Thank You!

Financial Policy and Signature on File

I authorize the release of any medical information to my primary care/referring physician, to consultants, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of benefits to Long Island Medical & Cosmetic Dermatology, P.C.

I understand that I am financially responsible for all services rendered and for the following reasons:

If: 1) I do not have the proper referral at the time of service 2) My referral is invalid/expired 3) I have given incorrect/invalid insurance information 4) Expenses are not covered by my insurance company 5) I have not met my deductible 6) The services rendered are deemed medically unnecessary by my insurance company *(This applies to present and future visits).*

Payment is required for all services at the time they are rendered including co-payments and any outstanding balances. A $20.00 fee for bounced checks will be added to your account and any non- urgent appointments will be rescheduled until balances are paid in full. In the event that your account must be turned over to collections, a $25.00 collection fee will be added to your account. Cancellations require 24 hours notice. Missed appointments without proper notification will be subject to a $50.00 missed appointment fee.

Your signature below signifies your understanding and willingness to comply with the policies of this office and your insurance plan.

Patient or Responsible Party Signature_____Date_____

HIPAA COMPLIANCE STATEMENT

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At Long Island Medical & Cosmetic Dermatology, P.C. we are committed to protecting your privacy. We comply with all federal, state, and local laws. This notice describes how we use your health information. It describes some of your rights and some of our responsibilities.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit our offices, we record your symptoms, physical examination, test results, diagnosis, and treatment. This information enables us to: plan for your care, communicate with others who care for you, report to your insurance carrier, bill for our work, and improve the quality of our care.

YOUR RIGHTS

Although your paper chart belongs to our practice, the information contained in the chart is yours. You have the right to: inspect your records, obtain a copy of your chart for a small fee, correct your records, and tell us not to release your information.

OUR RESPONSIBILITIES

We are required to: maintain the privacy of your health information; send needed health information to other medical providers, and release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission.

EXAMPLES OF HOW YOUR INFORMATION IS USED

Your health information will be recorded and used to plan your treatment. Reports may be sent to other doctors to help them plan your treatment. Bills will be sent to your insurance company. The information in the bills will include confidential information such as your name, address, diagnosis, and treatment. In providing your care, we may communicate with other individuals or businesses. Examples include other physicians and/or laboratories. To protect your privacy, we ask our business associates to safeguard your information.

OTHER NOTICES

We may leave a message at your home, at your business, on your answering machine or on your voicemail. We may mail you a postcard or other written notices. We may need to disclose your information to your family members or other people helping with your care. In doing so, we will use our best judgment. We may disclose information to others as required by law or if subpoenaed. If you were injured on the job, we will need to disclose your health information to your workers compensation insurance company. We may, from time to time, update these policies.

FOR MORE INFORMATION OR TO REPORT A PROBLEM If you have concerns or would like additional information, you may contact the practice's Privacy Officer at (631) 271-2769.

Signature_____ Date_____