# Roy S. Seidenberg, M.D.

317 East 34th Street, 5th Floor, New York, NY 10016

212.421.SKIN


**PATIENT REGISTRATION INFORMATION** TODAY'S DATE_____/_____/_____

| | | |
|---|---|---|
| Last Name | First Name | MI |
| Soc. Sec. # | Date of Birth | Sex ☐Male ☐Female |
| Patient Address | | Apt. |
| City, State, Zip | | ☐Single ☐Married ☐Divorced ☐Widow |
| Home Phone _____ May we leave private messages on voicemail? ____ Yes or ____ No | Work Phone _____ May we leave private messages on voicemail? ____ Yes or ____ No | Cell Phone _____ May we leave private messages on voicemail? ____ Yes or ____ No |

Occupation and Employer: _____

Employer Address: _____

**REFERRAL INFORMATION:**

Did a physician refer you to our practice? Yes (If yes, please indicate below) No

Referring Physician's Name and Phone Number: _____

Referring Physician's Address: _____

If not referred by a physician, how did you hear about our Practice? Friend/Family Website Job Newsletter Other

**PRIMARY CARE PHYSICIAN INFORMATION:**

Primary Care Physician's Name and Phone Number: _____

Primary Care Physician's Address: _____

**WHO TO CALL FOR AN EMERGENCY:**

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Please provide the name(s) of person(s) you would like your medical information released/provided to:

_____

Would you be interested in having communications sent to your email address? Yes No

Email address: _____

**PERSON RESPONSIBLE FOR PAYMENT** (Please complete only if different from patient)

| | |
|---|---|
| Guarantor Name | Soc. Sec. # |
| Relationship to Patient ☐Self ☐Spouse ☐Parent | Date of Birth |
| Address | Phone Number |
| Employer Name | Employer Phone # |
| Occupation | |

| For Physician's Use Only |
|---|
| I have reviewed this patient information form<br><br>Physician's Signature: _____ (Date) _____ |

**CHIEF COMPLAINT:** (DESCRIBE SYMPTOM(S) OR CONDITION(S) FOR WHICH YOU ARE SEEING THE DOCTOR) LIST ANY MEDICATIONS USED FOR THIS:

**SOCIAL HISTORY**: (CHECK ALL THAT APPLY)

Do you smoke? NO YES - Frequency _____ Do you use recreational drugs? NO YES - Frequency _____

Do you drink alcohol? NO YES - Frequency _____ Hobbies _____

**DRUG ALLERGIES:** (LIST TYPE OF REACTION)

ANESTHETICS _____ ASPIRIN _____

CODEINE _____ ERYTHROMYCIN _____

PENICILLIN _____ SULFA _____

TETRACYCLINE _____ OTHERS, please list _____

NON-DRUG ALLERGIES: LATEX OTHER (SPECIFY) _____

PRE-MEDICATION REQUIRED PRIOR TO SURGERY: NO YES - List drug, dosage & duration _____

**PRESENT / PAST MEDICAL HISTORY:** (LIST CONDITIONS AND DATE)

**SURGICAL HISTORY:** (LIST TYPE, REASON FOR SURGERY, DATE, SURGEON)

**DO YOU HAVE A PACEMAKER?** **YES** **NO**

ARE YOU CURRENTLY TAKING MEDICATION? YES NO IF SO, PLEASE LIST YOUR MEDICATIONS, DRUGS, ASPIRIN, AND OVER THE COUNTER PREPARATIONS / REMEDIES

| MEDICATION | INDICATION / CONDITION | DATE STARTED | DOSAGE (Milligrams) | HOW OFTEN |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**FAMILY HISTORY:**

DO YOU HAVE CHILDREN? Yes No Ages _____ MOTHER: Living Deceased Age ____ FATHER: Living Deceased Age _____

CHECK THE FOLLOWING MEDICAL CONDITIONS THAT HAVE OCCURRED IN YOUR FAMILY:

| Disease | Mother | Father | Blood Relative / Relation |
|---|---|---|---|
| Allergies | ☐ | ☐ | ☐ |
| Alzheimer's | ☐ | ☐ | ☐ |
| Arthritis | ☐ | ☐ | ☐ |
| Asthma | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ |
| Eczema | ☐ | ☐ | ☐ |
| Hayfever | ☐ | ☐ | ☐ |
| Other _____ | ☐ | ☐ | ☐ |

| Disease | Mother | Father | Blood Relative / Relation |
|---|---|---|---|
| Heart Disease | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ |
| Lung Disease | ☐ | ☐ | ☐ |
| Malignant Melanoma | ☐ | ☐ | ☐ |
| Parkinson's | ☐ | ☐ | ☐ |
| Psoriasis | ☐ | ☐ | ☐ |
| Skin Cancer | ☐ | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ | ☐ |
| Other _____ | ☐ | ☐ | ☐ |

**REVIEW OF SYSTEMS AND PAST MEDICAL HISTORY OF PATIENT** - *CHECK ALL THAT APPLY: USE "C" IF CURRENT, USE "P" IF PAST*

**CONSTITUTIONAL SYMPTOMS:**
___ Fever ___ Hair Loss
___ Weight loss ___ Weight Gain
___ Chills ___ Tremor
___ Nutritional Deficiencies
___ Excessive Sweating
___ Chronic Fatigue Syndrome
___ Other, specify _____

**EYES:**
___ Cataracts ___ Glaucoma
___ Eyestrain ___ Blurring
___ Inflammation
___ Wear Contacts
___ Other, specify_____

**EARS, NOSE, MOUTH, THROAT:**
___ Hearing Difficulty
___ Tinnitus (ringing in ears)
___ Dizziness ___ Wear Hearing Aid
___ Sinusitis ___ Postnasal Drip
___ Obstruction
___ Gum Disease
___ Chronic Sores
___ Herpes / Cold Sores
___ Hoarseness
___ Other, specify_____

**CARDIOVASCULAR:**
___ Stroke ___ Palpitation
___ Pacemaker ___ Rheumatic Fever
___ Faintness ___ Pain
___ High Blood Pressure
___ High Cholesterol ___ Raynaud's
___ Heart Surgery ___ Angina
___ Edema (swelling)
___ Heart Valve Replacement
___ Other, specify_____

**ENDOCRINE:**
___ Thyroid Disorder
___ Diabetes Mellitus
___ Excessive Hair, Face/Body
___ PCOS
___ Other, specify_____

**RESPIRATORY:**
___ Asthma ___ Chest Pain
___ Emphysema ___ Tuberculosis
___ Lung Disease ___ COPD
___ Breathing Disorder
___ Bronchitis, Chronic
___ Sputum, with blood
___ Cough, Chronic
___ Upper Respiratory Infection, Chronic
___ Other, specify_____

**GASTROINTESTINAL:**
___ Ulcer ___ Pain
___ Nausea ___ Constipation
___ Diarrhea ___ Vomiting
___ Appetite Decrease
___ Crohn's Disease
___ Colon/Intestinal Disorder
___ Other, specify_____

**GENITOURINARY:**
___ Discharge ___ Urgency
___ Sores ___ Incontinence
___ Hesitancy ___ Genital Warts
___ Herpes ___ Kidney Disease
___ Sexually Transmitted Disease

**INTEGUMENTARY:**
___ Skin Cancer(s) - describe below
___ Acne ___ Hives
___ Warts ___ Psoriasis
___ Eczema ___ Cystic Acne
___ Loss of Pigment
___ Dysplastic Nevi
___ Contact Dermatitis
___ Malignant Melanoma
___ Scarring/Keloids
___ Poor Healing After Surgery
___ Herpes simplex (cold Sores)
___ Herpes Zoster (shingles)
___ Sarcoidosis
___ Other, specify_____

**HEMATOLOGIC/LYMPHATIC:**
___ Anemia ___ Bruise Easily
___ Blood Clots ___ Excessive Bleeding
___ Bleeding Disorder
___ Other, specify_____

**NEUROLOGICAL:**
___ Headaches ___ Convulsions
___ Seizures ___ Migraine Headaches
___ Epilepsy ___ Fainting Spells
___ Memory Loss ___ Alzheimer's
___ Parkinson's
___ Other, specify _____

**PSYCHIATRIC:**
___ Stress ___ Depression
___ Nightmares ___ Insomnia
___ Anxiety ___ Suicidal Tendency
___ Treatment of Psychological Disorder
___ Attention Deficit Disorder
___ Other, specify_____

**ALLERGIC/IMMUNOLOGIC:**
___ Asthma ___ Frequent Infections
___ Allergies ___ Thyroiditis
___ Vitiligo ___ Addison's Disease
___ Pernicious Anemia
___ Hay Fever
___ Other, specify_____

**MALES ONLY:**
___ Urinary Difficulties
___ Prostatic Problems

**FEMALES ONLY:**
___ Chronic Vaginal Infections
___ Currently Pregnant
___ Currently Breastfeeding
___ Currently Taking Oral Contraceptives
Date of last menses_____

**INFECTIOUS:**
___ HIV Positive ___ AIDS Virus
___ Hepatitis ___ Liver Disease

**MUSCULOSKELETAL:**
___ Arthritis ___ Lupus
___ Joint Pain ___ Lupus of the Skin
___ Weakness ___ Joint Swelling
___ Artificial Joint/Prosthetic
___ Carpal Tunnel Syndrome
___ Chronic Back Pain
___ Fibromyalgia ___ Gout
___ Other, specify_____

**CANCER(S): LIST TYPE, DATE AND TREATMENT**

_____

_____

_____

I have completed this form to the best of my ability.

I do hereby agree to pay the full and entire amount of the consultation fee in addition to all bills for services rendered.

_____

(Sign Name) (Date)

As a member of a managed care group, I assume all responsibility for any services rendered that are not a part of my referral, whether or not covered or paid by my insurance, and I will pay for those services at the time they are rendered.

_____

(Sign Name) (Date)

**WORKER'S COMPENSATION & OTHER PERSONAL INJURY TESTIMONY IN COURT**

In order to provide the best possible service, care and availability to all of our patients, it is our policy not to testify in court, depositions, arbitrations, etc. relating to Worker's Compensation and other personal injury action.

_____

(Sign Name) (Date)

Consent for photograph release: I hereby give permission to Roy S. Seidenberg, M.D. to release the photographs taken for my medical record to my referring physician and/or insurance company or for educational purposes.

_____

(Sign Name) (Date)

**CONSENT FOR TREATMENT OF MINOR**

I hereby authorize,_____ M.D. to treat:

Patient Name (print): _____

Relationship: _____

Your Signature: _____ Date _____

Consent for emergency treatment of minor: Emergency treatment may be given in the event this patient is not accompanied by a parent or guardian.

Patient Name (print): _____

Relationship: _____

Your Signature: _____ Date _____

AUTHORIZATION - SIGNATURE ON FILE

**INSURANCE PATIENTS ONLY**

I request that payment of authorized insurance benefits be made either to me or on my behalf to Roy S. Seidenberg, M.D..
I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Patient's Name:_____
(Please Print)

Patient's Signature:_____

# PATIENT INFORMATION FORM

THE PRACTICE FINANCIAL POLICY WILL BE GIVEN TO THE PATIENT AT THE TIME OF REGISTRATION.
ALL PATIENTS MUST SIGN THIS FORM

## OUR FINANCIAL POLICY

The physicians and staff at our office are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

Unless other arrangements have been made by either yourself or your health coverage carrier, full payment is due at the time of service. For your convenience, we accept Visa, MasterCard, Discover and American Express.

## YOUR INSURANCE

If Roy S. Seidenberg, M.D. participates with your insurance plan, the fees for your services will be billed to your insurance plan provided the procedure or treatment you are receiving is considered medically necessary. However, you are responsible for the payment of your in-network deductible, co-payments and/or co-insurance at the time of the procedure. These fees are mandated by your insurance carrier and cannot be waived. Please be prepared to pay these fees at the time of your treatment/procedure. We accept cash, checks (for existing patients only), Visa, MasterCard, Discover, and American Express.

In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. In that event, you will receive a statement and payment in full will be expected.

If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare a statement for you to attach to your insurance claim form for processing of payment. In this case, the insurance carrier will send the payment directly to you. Therefore, charges for your care and treatment are due at the time service is rendered.

Some insurance plans will send a payment directly to you. If you receive payments for the services you received, you are responsible for forwarding the check directly to Roy S. Seidenberg, M.D. It is your responsibility to ensure Roy S. Seidenberg, M.D. is paid the amount that has been sent to you plus any remaining balance. Be advised that not remitting the payments to Roy S. Seidenberg, M.D. constitutes a breach of contract and Roy S. Seidenberg, M.D. will pursue all legal remedies available to it to obtain such payments.

## MINOR PATIENTS

For all servives rendered to minor patients, the adult accompanying the patient is responsible for payment.

## MISSED APPOINTMENTS & RETURN CHECK FEE

In order to provide the best possible service and availability to all our patients, it is our policy to charge our office visit fee ($150.00) for any appointments not canceled at least one day prior. Please call us as early as possible if you know you will need to reschedule your appointment to avoid this cancellation fee. If you make payment to the office by check, and it is returned by the bank for any reason, you will incur a fee of $30.00.

## COLLECTION ACCOUNTS

For all accounts with balances that are submitted to our collection agency for collection, you will be responsible for all legal and court fees as well as an additional fee of $25.00 for submission to our collection agency.

***I have read and understand the financial policy of the practice and I agree to be bound by its items. I also understand and agree that such terms may be amended from time-to-time by the practice.***

_____

(Signature of the Patient or Responsible Party) (Date)

_____

(Please Print the Name of the Patient)