PLEASE PRINT THIS FORM, FILL IT OUT ENTIRELY & BRING IT WITH YOU TO YOUR APPOINTMENT

FOR NEW PATIENTS ONLY

PATIENT NAME			
DATE OF BIRTH	**GENDER AT BIRTH:** **MALE** **FEMALE**		**PREFERRED PRONOUNS:**
STREET ADDRESS	**CITY**	**STATE**	**ZIP**
HOME TELEPHONE **EMAIL ADDRESS**	**BUSINESS TELEPHONE**	**CELL NUMBER**	
PRIMARY CARE DOCTOR	**ADDRESS**	**OFFICE TELEPHONE**	

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION		*SECONDARY INSURANCE INFORMATION*	
SUBSCRIBERS NAME		**SUBSCRIBERS NAME**	
RELATIONSHIP TO PATIENT	**SUBSCRIBERS DATE OF BIRTH**	**RELATIONSHIP TO PATIENT**	**SUBSCRIBERS DATE OF BIRTH**
HEALTH INSURANCE COMPANY		**HEALTH INSURANCE COMPANY**	
POLICY/ID NUMBER	**GROUP NUMBER**	**POLICY/ID NUMBER**	**GROUP NUMBER**

OFFICE POLICY

1. **Patient is to obtain a referral from their Primary Physician with the correct date of visit, if required by the insurance company.**
2. **Patient to pay co-payment at time of visit and any outstanding balances.**
3. **Under Federal Laws, you are required to pay your annual deductible and 20% coinsurance.**
4. **WE HAVE A 24-HOUR CANCELLATION POLICY. FAILURE TO COMPLY, YOU ARE RESPONSIBLE TO PAY $25.**

I authorize the release of any medical or other information to process a claim on my behalf. I authorize payment of benefits directly to the provider of the Skin Institute of New York. Any amount not paid by the insurance company, I agree to pay. I am aware of the 2017 Health Portability and Accountability Act (HIPAA) Privacy Notice.

May we discuss your medical information?

We suggest if you are between 18 and 25 and you have your parents help you, place your parent's information here.

On Answering Machine? (Please circle one) Yes or No

With another Person? (please circle one) Yes or No…….. if Yes (Please indicate below)

Name and Phone#_____

Relationship_____

PATIENTS SIGNATURE: _____DATE: _____

PLEASE FILL OUT THE OTHER SIDE

PAST MEDICAL HISTORY: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplant
BPH
Breast Cancer
Colon Cancer
COPD
Other _____

Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood Pressure
HIV/AIDS
Hay Fever/Allergies
High Cholesterol

Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Pacemaker
Radiation Treatment
Seizures
Stroke
Thyroid Problems (Hyper / Hypo)

Are you pregnant? YES NO

PAST SURGICAL HISTORY:

_____

SKIN DISEASE HISTORY: (Please circle all that apply)

Psoriasis
Eczema
Flaking or Itchy Scalp
Precancerous Moles
Melanoma (Family or Self)
Warts
Actinic Keratosis

Keratoacanthoma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Squamous Cell Skin Cancer
Acne

Do you wear sunscreen?
YES NO
If yes, what SPF? _____
Do you tan in a tanning salon?
YES NO

MEDICATIONS: (Please enter all current medications)

_____
_____

DRUG ALLERGIES:

_____

Cigarette Smoking: (Please circle one)
Never Smoked
Quit: Former Smoker
Smokes Daily

Alcohol intake:
Less than one drink per day
1-2 drinks per day
3 or more drinks per day

Have you had your Flu vaccine within the past year? YES NO
Have you had your Pneumonia vaccine? YES NO
Do you have an advanced care directive (Proxy)? YES NO

Referring Physician (if applicable):
Physician Name: _____ Physician Phone/Fax: _____ Physician Address: _____

How did you hear about us?:
Google/Internet Search _____
ZocDoc _____
Yelp _____
Facebook _____
Instagram _____
Website_____
Other_____

PLEASE FILL OUT THIS ENTIRE BOX