WELCOME TO THE OFFICE OF DR. MARC AVRAM.
PLEASE TELL US ABOUT YOURSELF:

Last Name:_____ First Name:_____

Address:_____ Apt. #:_____

City:_____ State:_____ Zip:_____

Home Phone: _____ Business Phone:_____

Cell Phone:_____ Email:_____

Gender: M or F

Date of Birth: _____ Do you need prophylaxis?:_____

Please check where we can leave a message if necessary: Home Business Cell

If you provided us with an email address, can we contact you with general office correspondence and updates? Please circle: YES NO

Emergency Contact Name & Phone Number: _____

Employer:_____ Occupation:_____

Name of guardian, if patient is a minor:_____

Reason for being seen today:_____

How did you hear about us?_____

Preferred pharmacy Name: _____ Phone#: _____

All patients:
I understand that Dr. Marc Avram does not participate with my insurance plan and that the payment is due in full at the time of service.

Signature:_____ Date:_____

History and Intake Form

Medications: (Please enter all current medications)

_____

_____

_____

Allergies: (Please enter all allergies)

_____

_____

_____

Is it possible you are pregnant?_____
Are you breast feeding? _____

Past Medical History: (please circle all that apply)

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Asthma	End Stage Renal Disease	Lymphoma
Atrial fibrillation	GERD	Prostate Cancer
Bone Marrow Transplantation	Hearing Loss	Radiation Treatment
Breast Cancer	Hepatitis	Seizures
Colon Cancer	High Blood pressure	Skin Cancer
COPD	HIV/AIDS	Stroke
Coronary Artery Disease	High Cholesterol	
	Thyroid Problems	NONE

If you have had any of the above, please describe in detail:

_____

Interest In: (please circle all that apply)

Hair Transplantation	
Hair loss	Botox
PRP	Fillers
Wrinkles	Scar/ Acne Scarring
Double Chin	Chemical Peel
Broken Blood Vessels	Aging Face Evaluation
Tattoo Removal	Freckle/ Age Spot Removal

Other _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. A patient copy of the notice is available in the waiting area. If you would like a copy please notify the front desk. Please sign this form to acknowledge that you understand the location of this Notice. You may refuse to sign this acknowledgement, if you wish.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

The patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain acknowledgement.

☐ We weren't able to communicate with the patient.

☐ Other *(Please provide specific details.)* _____

_____

_____

_____

Employee Signature

_____

Date

CONSENT FOR USE/DISCLOSURE OF HEALTH INFORMATION

Patient's Name:

Patient's Date of Birth:

Notice to Patient:
By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of treatment, various activities associated with payment and health care operations. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the notice accompanying this consent form, please ask for one. We encourage you to read it since it provides the details on how information about you may be used and/or disclosed, and describes certain rights you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have a right to revoke your consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this consent. You should also understand that if you revoke this consent, we may decline to treat you.

You are entitled to a copy of this consent form after you have signed it.

(To be completed by patient or patient's representative)

I, _____, have read the contents of this consent form and the **Notice of Privacy Practices**. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

_____ _____
Patient's signature or signature of patient's representative Date

_____ _____
Printed name of patient's representative Relationship to patient

Our Privacy Officer can be contacted as follows:

Name of Privacy Officer: Michele Egan
Practice Address: 905 Fifth Ave, New York, NY 10021
Phone: (718) 852-4646
Fax: (718) 624-5972