Robin R. Blum, MD, FAAD
Medical & Cosmetic Dermatology

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(212) 969-9655 | Fax (212) 969-9665

TODAY'S DATE: ____________________________

NAME: ____

Date of Birth: ________________________ Gender: □ Male □ Female

ADDRESS: ____ APT/SUITE: ________________

CITY: ____________________________________ STATE: ________ ZIP CODE: ________________

PRIMARY NUMBER: (__________) ______________-__________________ □ CELL □ HOME □ WORK
□ OK to leave message with detailed information
□ Leave message with call back number only

SECONDARY NUMBER: (________) ______________-__________________ □ CELL □ HOME □ WORK
□ OK to leave message with detailed information
□ Leave message with call back number only

EMAIL: ____

PHARMACY NAME: ______________________________PH. NUMBER: ____________________________

STREET: ____ ZIP CODE: ________________________

PRIMARY CARE PROVIDER NAME: ____

PH.NUMBER:____

□ OK to review and communicate results with primary care/referring physician

HOW WERE YOU REFERRED?

□ REFERRING PHYSICIAN: ____

□ FAMILY/FRIEND: (Please Provide Name) ____

□ Zocdoc.com □ Insurance Website □ Mt. Sinai Website □ Internet Search

□ Other: ____

IN CASE OF AN EMERGENCY, PLEASE CONTACT:

NAME: ____ RELATIONSHIP: _______________________

PHONE NUMBER: (________) ______________-________________

Authorization to release medical information/Protected Health Information (PHI):

□Yes, I authorize Dr. Blum and her associates to share/release medical and billing information about myself with the following:

Name: ____ Relationship: ______________________

Phone number: ____

Check all that apply:

□ Scheduling/Appointment information

□ Medical information, including diagnosis, symptoms, medications, and treatment plan

□ Lab/test results

□ Billing and payment information

PatientSignature:____

□ No, I do not authorize Dr. Blum and her associates to share/release medical and billing information about myself, with the exception of information releasable through HIPAA.

Consent for Communication via E-mail and Text

I hereby consent to have my physician, Dr. Robin Blum and/or members of her staff communicate with me vial e-mail or text regarding all aspects of my medical care and treatment, including test results, prescriptions, appointments, billing, etc. I understand that e-mail and texting is not a confidential method of communication. I further understand that there is a risk that e-mail or text communications between my physician or members of her staff and me regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail or text communication between my physician and her staff may be printed out and made part of my medical record. I understand that in an urgent or emergent situation I should call my provider or go to the emergency room and not rely on e-mail or text.

Patient Signature:____

PAST MEDICAL HISTORY:

Please Circle below if you have a history of: □ **N/A**

ANXIETY	DEPRESSION	HYPERTHYROIDISM
ARTHRITIS	DIABETES	HYPOTHYROIDISM
ASTHMA	END STAGE RENAL DISEASE	LEUKEMIA
ATRIAL FIBRILLATION	GERD	LUNG CANCER
BONE MARROW TRANSPLANT.	HEARING LOSS	LYMPHOMA
BREAST CANCER	HEPATITIS	RADIATION TREATMENT
COLON CANCER	HIGH BLOOD PRESSURE	SEIZURES
COPD	HIV/AIDS	STROKE
CORONARY ARTERY DISEASE	HIGH CHOLESTEROL	PACEMAKER

□ **OTHER:**

FOR WOMEN, are you currently: □Pregnant □ Trying to Get Pregnant □Breastfeeding □N/A

PAST SURGICAL HISTORY:

____
____
____

MEDICATIONS: (please list all current meds including topicals) □**N/A**

____________________ ____________________ ____________________
____________________ ____________________ ____________________
____________________ ____________________ ____________________

ALLERGIES TO MEDICATION: □ YES □ NO □ N/A

IF YES, Please Indicate: ____________________ ____________________

____________________ ____________________ ____________________

SKIN DISEASE HISTORY: (please circle all that apply)

Acne
Actinic keratoses
Blistering Sunburns
Eczema
Flaking or itchy scalp
Dry Skin
Poison ivy
Precancerous moles
Psoriasis

NONE

Other ____

HAVE YOU EVER HAD A SKIN CANCER? □ YES □ NO

- If YES, which type?

□ Melanoma When? ____________ Body Site? ____________

□ Basal Cell Carcinoma When? ____________ Body Site? ____________

□Squamous Cell Carcinoma When? ____________ Body Site? ____________

Melanoma Family History: Mother Father Sister Brother Daughter Son Other

SOCIAL HISTORY:

Cigarette Smoking/Tobacco Use:
□ Never □ Smokes/Uses Tobacco Less Than Daily
□ Quit: Former Smoker/User □ Smokes/Uses Tobacco Daily

Alcohol:
□ None □ 1-2 drinks per day
□ Less than 1 drink a day □ 3 or more drinks per day

What is the reason for your visit today?

____
____
____

Would you like to discuss any of the following?

□Botox □ Fillers □Sculpsure/Laser body contouring □Photofacial Skin Rejuvenation
□Laser hair removal □Chemical peels □Uneven skin pigmentation □Skin tag removal
□Other

FINANCIAL POLICY

We are dedicated to providing you with the best possible care and services, and as a commitment to you, we participate with a majority of health insurance plans. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees or your financial responsibility.

It is important for you to familiarize yourself with the specific requirements and policies of your insurance plan.

- If your insurance plan requires a referral from your Primary Care Physician in order for services to be covered, it is your responsibility to obtain the referral prior to your appointment. If a referral is not presented at your appointment, you will be responsible for the entire cost of the visit.
- Payments are expected at the time services are rendered.
- If your insurance requires you to meet an annual deductible before your healthcare is covered, you will be billed for all services rendered until you meet your deductible.
- If any services are denied as Out-Of-Network, not covered by the terms of the policy, policy not in force, not medically necessary, or have a deductible/co-insurance issue, you will be billed and are responsible for the balance.
- If a biopsy or lab specimen is collected at your visit, it is sent to an outside lab for processing. This is a separate service that may incur a bill if you have a lab fee or deductible fee and will be billed separately by the lab.
- If you fail to notify our practice of any insurance changes, you will be fully responsible for any fees not paid by your insurance company.

Cancellation Policy: As a courtesy, we make every effort to confirm appointments in advance; however, it remains your responsibility to keep appointments. If you are unable to keep an appointment, we ask that you give a 24 hour notice and if you need to cancel or reschedule an appointment, please speak to the receptionist directly. Messages left via phone, email, or text, are not considered as valid. ***In the event you are unable to give sufficient notice or have missed your appointment, a cancellation fee of $50 will automatically be billed to your account.***

For all cosmetic appointments, a $200 deposit is required to secure your appointment. ***A cancellation of cosmetic appointments with less than 24 hours' notice is subject to loss of deposit.***

Returned checks will result in a $25 service charge.

Signature: ______________________________ **Date:** ____________________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AS WELL AS HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY:

In general, The HIPAA (Health Insurance Portability and Accountability Act) privacy rule gives individuals the right to request restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to home or office, leaving messages on answering machines, and leaving lab or procedure results with a spouse.

I acknowledge that I have been provided a copy of Robin R. Blum, MD,PC/Central Park South Dermatology Notice of Privacy Practices and have been provided an opportunity to review it. I authorize release of medical information to my Primary Care Physician or Referring Physician, Consultants, if needed, and as necessary to process insurance claims, insurance applications, and Prescriptions. I also authorize payment of medical benefits to Robin R. Blum, MD, PC.

If you have any questions regarding this notice, please contact Dr. Robin Blum (privacy officer) at 212-969-9655.

Signature: ____ **Date:** ______________________