Patient Information Form: Today's Date:_____

Last Name: _____ First Name: _____

Date of Birth: _____ Age: _____ Male ☐ Female ☐

Address: _____

City: _____State: _____ Zip: _____

Race: (please circle) American Indian, Alaska Native, Asian, Black/African American, Native Hawaiian/Pacific, Caucasian. Hispanic/Latino, Undefined, Other_____

Telephone Contact Numbers:	May we call you at this number	May we leave a message
Home Phone: _____	☐ YES ☐ NO	☐ YES ☐ NO
Mobile_____	☐ YES ☐ NO	☐ YES ☐ NO
Work Phone: _____	☐ YES ☐NO	☐YES ☐ NO

Best number to reach you to confirm appointment (please circle): Home Mobile Work

Email: _____

Pharmacy name: _____

Pharmacy phone number: _____

Pharmacy address: _____

Employer Information:

Employer: _____ Occupation: _____

Referral Information:

Referred by: _____ Phone #: _____

Address/State/Zip: _____

Primary Physician: _____Telephone _____

Address _____

In case of emergency, who should be notified? _____

Telephone _____

Insurance Information:

Name of Insurance Company: _____

Name of Subscriber: _____ Subscriber's Date of Birth: _____

ID#: _____ Group#: _____

Office Policy:

I authorize the release of medical information to my primary care or referring physician to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. **I understand that I am responsible for any co-payments, deductibles, and any non-covered, charges that my insurance company denies.**

For patients with Medicare:
I authorize any holder of medical or other information about me to release to the Social Security Administration and the Centers for Medicare and Medicaid Services or their intermediaries or carriers, or to the billing agent of this physician, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

If you have a balance with Dr Salob, would you like to have the billing statement emailed to you instead of being mailed. ☐ YES ☐ NO

Patient Signature: _____ Date: _____

HIPAA Privacy Act:

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly,**
- **Obtain Payment from third-party payers,**
- **Conduct normal healthcare operations such as quality assessments and physician certifications.**

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at 115 E. 61st Street (Suite 7E), New York, NY 10065 to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (Please print clearly) _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	Initials:	Reasons:

Salob Dermatology is not permitted, by law, to provide medical information to anyone other than the patient except for treatment, payment and healthcare operations as described in the Notice of Privacy Practices.

The staff at Salob Dermatology would like to know with whom, if anyone, you want us to be able to discuss your treatment, treatment plans, condition updates, lab results, appointment information, billing information, or picking up of samples. This would also include leaving messages on your answering machine or in your voicemail box. If you would also like us to communicate with you by e-mail to address your health information or for specials, promotions, or other office events, please indicate so below.

Please complete the following so that the individuals you specify can have access to your information as described above.

I, _____, as a patient of Salob Dermatology, authorize the release of my medical information regarding my treatment and care to the following individuals upon their request.

_____	_____	_____	_____
Name (please print)	Date of Birth	Relationship	Phone Number
_____	_____	_____	_____
Name (please print)	Date of Birth	Relationship	Phone Number

_____ _____
Signature of Patient/ Authorized Representative Date

Credit Card Information:

*MUST PUT CREDIT CARD INFORMATION. ALL RECORDS ARE KEPT CONFIDENTIAL.

In providing credit card information below, you authorize payment by credit card for services in the absence of coverage by your health plan as described above.

Name on Credit Card: _____

Credit Card #: _____

Card Type: Visa MasterCard American Express (Please circle one)

Expiration Date: _____ CVV: _____

Patient Signature: _____ Date: _____

If you have an unpaid balance, would you prefer to be called before your credit card is charged? Yes or No

Medical History:

Reasons for today's visit: _____

_____etc.

Have you ever had dental anesthesia? ☐ YES ☐ NO Any bad reaction? ☐ YES ☐ NO

List all medications you are currently taking (including prescriptions, over-the-counter medications, vitamins and herbs):

_____

_____

_____

Please list any allergies to oral or topical medicines: _____

_____

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

Lungs	**Yes**	**No**	**Other Systemic**	**Yes**	**No**
Bronchitis	☐	☐	Diabetes	☐	☐
Emphysema	☐	☐	Thyroid	☐	☐
Asthma	☐	☐	Kidney	☐	☐
Chronic Cough	☐	☐	Bladder	☐	☐
Shortness of Breath	☐	☐	Gastrointestinal	☐	☐
Wheezing	☐	☐	Hepatitis	☐	☐
			Arthritis/Joint Deformity	☐	☐
Cardiovascular			Artificial Joint	☐	☐
High Blood Pressure	☐	☐	Convulsions or seizures	☐	☐
Chest Pain	☐	☐	Arthritis/Joint Deformity	☐	☐
Heart Attack	☐	☐	Fainting	☐	☐
Heart Murmur	☐	☐	Anxiety/depression	☐	☐
Irregular Heartbeat	☐	☐	Excess fatigue	☐	☐
Inflammation of vein	☐	☐			
Blood clot	☐	☐			
Pacemaker	☐	☐			

Cancer ☐ ☐ If YES, what type of cancer? _____

Skin

When you are exposed to the sun do you: ☐Tan only ☐Tan and burn ☐Burn

Have you ever had skin cancer? ☐YES ☐NO, If YES, please explain: _____

_____

Has anyone in your family had melanoma? ☐YES ☐NO, If YES, who? _____

Have you ever been in a tanning booth/bed? ☐YES ☐NO, If YES, approximate # visits: _____

Have you ever had cold sores? ☐YES ☐NO

Have you ever had radiation treatment? ☐YES ☐NO, IF YES please explain:_____

_____

Social History:

Do you drink alcohol? ☐YES ☐NO If YES, how much per week? _____

Do you smoke? ☐YES ☐NO If YES, how much?_____

(Women) Are you pregnant? ☐YES ☐NO Due Date: _____

Are you trying to conceive? ☐YES ☐NO

Cosmetic Questionnaire: Please check all that are of interest to you:

☐ Botox® Cosmetic

☐ Chemical Peels

☐ Filler Agents: Radiesse®, Juvederm™, Restylane®, etc.

☐ Treatment of Facial Lines/Wrinkles

☐ Laser Treatment of Facial Veins/Redness

☐ Laser Treatment of Liver/Age/Brown Spots

☐ Laser Hair Removal

☐ Treatment of Uneven Skin Tone

☐ Treatment of Excessive Sweating

☐ Effective Skin Care