

MANHATTAN DERMATOLOGY, PLLC

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NAME OF PATIENT: (LAST) _____ (FIRST) _____ (M.I.) _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____ AGE: _____

SEX: M / F MARITAL STATUS: S / M / D / W / DP

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME #: () _____ OFFICE #: () _____ CELLPHONE #: () _____

FAX NUMBER: () _____ PHARMACY NUMBER: () _____

EMERGENCY CONTACT PHONE NUMBER: () _____ NAME: _____

NAME OF EMPLOYER: _____ OCCUPATION: _____

NAME OF PRIMARY INSURANCE COMPANY: _____

NAME OF INSURED: (LAST) _____ (FIRST) _____ (M.I.) _____

RELATIONSHIP TO INSURANCE HOLDER: SELF / SPOUSE / CHILD / OTHER DATE OF BIRTH: _____

INSURANCE HOLDER'S SOCIAL SECURITY NUMBER: _____ GROUP NUMBER: _____

NAME OF SECONDARY INSURANCE: _____ ID NUMBER: _____

NAME OF INSURED: _____ GROUP NUMBER: _____

WERE YOU REFERRED BY A PHYSICIAN? (IF SO, PLEASE PROVIDE NAME) _____

ADDRESS OF REFERRING PHYSICIAN: _____

NAME OF PRIMARY CARE PHYSICIAN: _____ TELEPHONE: () _____

ADDRESS: _____ ZIP CODE: _____

IF NOT REFERRED BY A PHYSICIAN, HOW DID YOU HEAR ABOUT OUR OFFICE? _____

PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT APPLY TO YOU:

SKIN CANCER

HEART DISEASE

BLEEDING PROBLEMS

ASTHMA

LIVER DISEASE

STOMACH ULCERS

ECZEMA

HERPES

DEPRESSION

SEASONAL ALLERGIES

HIV

PREGNANT

PSORIASIS

HPV

TRYING TO CONCEIVE

DIABETES

MRSA

BREAST FEEDING

FAMILY HISTORY OF SKIN CANCER:

FAMILY HISTORY OF SKIN DISEASE:

LIST ALL ALLERGIES:

LIST ALL MEDICATIONS, SUPPLEMENTS, VITAMINS:

DESCRIBE TYPE, LOCATION AND DURATION OF YOUR SKIN TROUBLE:

CANCELLATION POLICY:

IF YOU MUST CANCEL OR RESCHEDULE YOUR APPOINTMENT, WE REQUEST THAT YOU DO SO AT LEAST ONE BUSINESS DAY PRIOR TO YOUR APPOINTMENT. IF YOU MISS AN APPOINTMENT WITHOUT DOING SO, WE RESERVE THE RIGHT TO REFER YOU TO ANOTHER PHYSICIAN OR CHARGE A CANCELLATION FEE IF THE APPOINTMENT WAS FOR A SURGICAL OR LASER PROCEDURE.

FOR SURGICAL PROCEDURES, YOU MUST CANCEL 24 HOURS PRIOR TO YOUR APPOINTMENT OR YOU WILL BE CHARGED A \$250 FEE.

FOR MOH'S MICROGRAPHIC SURGERY APPOINTMENTS, YOU MUST CANCEL ONE WEEK PRIOR TO YOUR APPOINTMENT, OR YOU WILL BE CHARGED A \$250 FEE.

FINANCIAL POLICIES:

ALL COPAYS ARE EXPECTED AT THE TIME OF THE VISIT.

IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR INSURANCE PLAN'S POLICIES AND TO GET REFERRALS FROM YOUR PRIMARY CARE PHYSICIAN IF REQUIRED BY THE PATIENT'S INSURANCE PLAN. EVEN IF WE ARE IN NETWORK WITH YOUR INSURANCE, DEDUCTIBLES OR COINSURANCE MAY APPLY, WHICH MEANS YOU MAY BE RESPONSIBLE FOR A PORTION OF THE CHARGES.

THIS FORM AND MY SIGNATURE AFFIXED HERETO MAY SERVE AS A SIGNATURE-ON-FILE TO BE USED TO AUTHORIZE DISCLOSURE OF THE MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM, INCLUDING THE DIAGNOSIS AND RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME, AND TO FILE ALL FUTURE INSURANCE CLAIMS RELATED TO MY CARE.

I ALSO AUTHORIZE MY INSURANCE COMPANY TO PAY DIRECTLY TO DR. WILLIAM T. LONG, DR. WENDY LONG MITCHELL, DR. SHARI MARCHBEIN AND/OR DR. GEORGE KIHICZAK THE AMOUNT DUE TO ME IN PENDING CLAIMS FOR MEDICAL OR SURGICAL TREATMENT OR SERVICES RENDERED TO ME.

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THIS PRACTICE'S NOTICE OF PRIVACY PRACTICES.

PATIENT'S OR RESPONSIBLE PARTY'S NAME: _____

PATIENT'S OR RESPONSIBLE PARTY'S SIGNATURE: _____

DATE SIGNED: _____