

**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 #: (    ) \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_ @ \_\_\_\_\_ 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:

- |                      |                      |  |                    |
|----------------------|----------------------|--|--------------------|
| ASTHMA               | HEART DISEASE        | ONYCHOMYCOSIS                                  | STOMACH ULCER/GERD |
| BLEEDING PROBLEMS    | HEPATITIS A B C      | PARKINSON'S DISEASE                            | THYROID DISEASE    |
| BREAST FEEDING       | HERPES               | PREGNANT/TRYING TO CONCEIVE                    | TINEA VERSICOLOR   |
| CHICKEN POX/SHINGLES | HIV                  | RHEUMATOID ARTHRITIS/LUPUS                     | URTICARIA (HIVES)  |
| DEPRESSION           | HPV                  | ROSACEA  | VITILIGO           |
| DIABETES I OR II     | KIDNEY/LIVER DISEASE | SEASONAL ALLERGIES                             |                    |
| ECZEMA               | MRSA                 | SKIN CANCER/OTHER CANCER, PLEASE SPECIFY _____ |                    |

**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 COSMETIC PROCEDURE.

FOR SURGICAL PROCEDURES OR LASER HAIR REMOVAL 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.

FOR SCITON LASER APPOINTMENTS, YOU MUST CANCEL ONE WEEK PRIOR TO YOUR APPOINTMENT, OR YOU WILL BE CHARGED A \$500 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: \_\_\_\_\_