GOLDMAN DERMATOLOGY, PLLC

PATIENT INFORMATION FORM

Patient Name: _______________________________________ Social Security #: ____

Address: __________________________Apt: ____________ Date of Birth: ________/________/________ Gender ( ) M ( ) F

City: _____________________ State: ______ Zip: ________ Marital Status ( ) S ( ) M ( ) D ( ) W

Employer: _________________________________

Phone #'s: (H): ( ) _______________________________________

(W): ( ) _______________________________________

(C): ( ) _______________________________________

Name of Parent or Guardian (if minor):

____

Referring Physician: ___________________________

Email: ____

Or Friend: ___________________________________

Permission to contact by E-mail: ( ) YES ( ) NO

Referring Physician Phone #: ____________________

Emergency Contact Name: ______________________

Relationship to patient: _________________________

Emergency Contact #: __________________________

PHARMACY INFORMATION

Pharmacy Name: ____

Pharmacy Phone #: ____

Pharmacy Address: ____

____

PRIMARY INSURANCE

Insurance Name: ______________________________

Member ID #: _________________________________

Group #: _______________________________________

Insurance Phone #: ______________________________

Primary Care Physician: _______________________________________

Phone# & Address: ____

____

____

If Insurance is other than patients:

Insured Name: _________________________________

Relationship to patient: __________________________

Insured's Date of Birth: __________________________

Insured's SS#: _________________________________

SECONDARY INSURANCE

Insurance Name: ____

Member ID# ____

Group # ____

Insurance Phone #: ____

Can we leave messages about lab or biopsy results on your phone? ____Yes ____No

If you would like the doctor to see you alone, Please let the medical assistant in the room know.

I hereby authorize GOLDMAN DERMATOLOGY, PLLC to furnish information concerning my illness and treatment to my insurance carriers.

I authorize payment of medical benefits to GOLDMAN DERMATOLOGY, PLLC.

I understand that I am responsible for any part of the charges that are not covered by my medical coverage.

I HAVE RECEIVED A COPY OF THE PATIENT PRIVACY NOTICE.

Signed: ____ Date: ____

(Signature of Patient or Parent/ Guardian if patient is a minor)

*Please note you can pay your balances and request refills online at www.goldmandermatology.com

GOLDMAN DERMATOLOGY, PLLC
150 Broadway, Suite 1110, New York, NY 10038
(212) 962-1115 fax (212) 962-1246
www.goldmandermatology.com

PRIVACY PRACTICES ACKNOWLEDGEMENT

☐ I have received your Notice of Privacy Practices and/or I have been provided an opportunity to review it.

☐ I agree that telephone messages regarding my appointments, prescription renewals, lab results, and all other Protected Health Information* ("PHI") may be left for me on Voicemail systems and answering machines at the following telephone numbers, in addition to any other numbers provided to you by me:

(___ ___ ___) ___ ___ ___ - ____ ____ ____ ____ Home / Office / Cell / Other _________________

(___ ___ ___) ___ ___ ___ - ____ ____ ____ ____ Home / Office / Cell / Other _________________

(___ ___ ___) ___ ___ ___ - ____ ____ ____ ____ Home / Office / Cell / Other _________________

(If we need to contact you with lab results, please place a check mark next to the preferred contact number, if any)

☐ I agree that my PHI may be shared with my spouse
☐ I agree that my PHI may be shared with my other medical providers
☐ I agree that my PHI may be shared with the following other people:

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

☐ I understand that I can change any of the foregoing agreements, at any time, by giving written notice to GOLDMAN DERMATOLOGY, PLLC to the attention of the HIPAA Compliance Officer.

☐ I agree that my PHI may be shared with my credit card company/companies if I contest any credit card charges, so that GOLDMAN DERMATOLOGY, PLLC can submit records to support its charges.

☐ I agree that GOLDMAN DERMATOLOGY, PLLC may contact me at any email addresses provided to you by me regarding both PHI and non-PHI.

*as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time ("HIPAA")

Patient Name [please print clearly]: ____

Signature: ____ Date: ______________________

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name [print]: __________________ Relationship to Patient: ☐ Parent ☐ Legal Guardian

DERMATOLOGY MEDICAL HISTORY

Patient Name:____Date:______________________

Reason for today's visit:____

Are you allergic to any medications? ___Yes ___No

1.__________________________________ 2.________________________________
3.__________________________________ 4.________________________________

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

1.__________________________________ 2.________________________________
3.__________________________________ 4.________________________________

Do you have now, or have you ever had diseases or conditions of: (Please check Yes or No)

Lungs:
Bronchitis __Yes __No
Emphysema __Yes __No
Asthma __Yes __No
Chronic Cough __Yes __No
Morning Cough __Yes __No
Wheezing __Yes __No

Cardiovascular:
High Blood Pressure __Yes __No
Chest Pain __Yes __No
Heart Attack __Yes __No
Irregular Heartbeat __Yes __No
Phlebitis __Yes __No
Inflammation of veins __Yes __No
Blood Clots __Yes __No
Pacemaker __Yes __No
Fainting __Yes __No

Other Systemic:
Diabetes __Yes __No
Excessive thirst/hunger __Yes __No
Thyroid __Yes __No
Kidney __Yes __No
Bladder __Yes __No
Frequency/burning __Yes __No

Gastrointestinal:
Stomach absorptive disorder __Yes __No
Nausea, vomitting, diarrhea when taking antibiotics __Yes __No
Yeast infection when taking antibiotics __Yes __No
Arthritis/Joint Deformity __Yes __No
Arthralgia __Yes __No
Limited motion __Yes __No
Artificial joint __Yes __No
Convulsions, Seizures __Yes __No

Skin:
When you are exposed to the sun do you: __Tan only __Tan and burn __Burn only
Have you ever had skin cancer? __Yes __No
Has anyone in your immediate family had skin cancer? __Yes __No If yes, what type?_________
Do you have a history of any specific skin diseases? __Yes __No
If yes, please list:____
Do you develop skin rashes in reaction to __Medications __Food __Environment?
List any other diseases or conditions:____
List any surgical procedures you have had in the last 6 months:_______________________________

Please answer the following questions:
Have you had or have you been exposed to HIV/AIDS __Yes __No
Do you bleed easily? __Yes __No
(Women) Are you pregnant? __Yes __No

__Please check here if you would like to learn more about our skin care products or if you would like a consultation with our esthetician. ___ Not Interested

Please indicate whether you are interested in learning more about the following: (Please Check)
__BOTOX__JUVEDERM__RESTYLANE__LASER HAIR REMOVAL__MICRODERMABRASION __CHEMICAL PEELS__LASER FOR BROKEN VEINS__FRAXEL FOR ACNE SCARS __LASER FOR BROWN SPOTS__SCLEROTHERAPY__PRP HAIRLOSS__MICRONEEDLING __COOLSCULPTING__WRINKLES
All procedures are done in the office. If any of these are of interest to you, please let us know and we can discuss them with you as well as provide information.

Completed by: __Patient
__Medical Assistant

____
Patient Signature Date