ARIEL OSTAD, MD PC * DERMATOLOGIC SURGERY OF NY
897 Lexington Avenue, New York, NY 10065 Phone: 212-517-7900

PATIENT REGISTRATION INFORMATION

LAST NAME: ____ FIRST NAME: ______________________________ MI: _____

STREET: ____ APT #: _____________________

CITY: ____ STATE: ____________ ZIP: ___________________

SEX: (M/F) ________HOME PHONE: _____________________________ EMAIL **:____

WORK PHONE **: _______________________________________ DATE OF BIRTH: ___________________________

SOCIAL SECURITY #: _________________________________ CELL PHONE: _____________________________________

MARITAL STATUS: ___Married ___Single ___Significant Other IN CASE OF EMERGENCY, PLEASE CONTACT:

____ RELATIONSHIP TO YOU: ___________________________________

PHONE: _______________________________________ ARE YOU EMPLOYED? _____NO _____YES: If yes, complete below.

EMPLOYER NAME: ____ (** **MAY WE CONTACT YOU**? ___YES ___NO)

***** Were You Referred By a Doctor? ___No (See Below) ___Yes: If Yes, please give us information on the doctor:**

REFERRING MD NAME: ____ PHONE: _________________________________

ADDRESS: ____

Referred By: ____Website ____Family/Friend ____Saw Dr. Ostad on TV ___New York Best Doctors Issue ___Magazine /Newspaper Article

OTHER: ____

HEALTH INSURANCE INFORMATION

PRIMARY INSURANCE NAME / CLAIMS ADDRESS: ____

____ PHONE: ____

ID#: ____ GROUP #: ____

ARE YOU THE POLICYHOLDER? ____YES ___NO: **If not, please complete the information below on the policy holder.**

INSURED'S NAME: ____ DOB: _____________________________________

SOCIAL SECURITY #: ____ SEX: (M/F) ________

EMPLOYER NAME: ____ EMPLOYER PHONE: ________________________________

SECONDARY INSURANCE- NAME: ____

PHONE: _______________________________ ID#: __________________________________ GROUP #: _________________________

INSURED'S NAME: ____ DOB: _____________________________________

SOCIAL SECURITY #: ____ SEX: (M/F) ________

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Ariel Ostad, MD, PC, and Dermatologic Surgery of NY; its associate physicians and para-professionals, to bill the above referenced health insurance companies on my behalf for any/all services performed. I hereby assign all insurance payment benefits directly to this physician group should they accept assignment to my insurance carriers. I understand that any payments that I may receive directly, for services which were billed on my behalf by the physicians, must be turned over to the physician. I understand that I am financially responsible for any/all charges not payable by my insurance carriers. I hereby authorize the release of any information necessary to secure payment of benefits. I affirm that I have been offered a copy of the patient bill of rights and provider information and may ask for a personal copy to take with me.

____ ________________________________

PATIENT / LEGAL GUARDIAN SIGNATURE DATE

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FINANCIAL POLICY

Please take a few moments to read the following information regarding the office financial policy:

1. Your insurance may require authorization from your Primary Care Physician (PCP) in order to be examined. It is ***your responsibility*** to obtain the referral/authorization from the primary doctor (PCP) ***in advance*** of your scheduled appointment to allow their office staff to generate an active referral on your behalf. (Some referrals are paper and some are electronic). **Please be aware that if you arrive without a valid referral/authorization, your appointment will have to be rescheduled.**

THIS IS YOUR INSURANCE COMPANY POLICY…NOT OURS!

2. You may also require authorization from your PCP for all required follow-up visits. It is your responsibility to call your PCP to inquire if additional referrals are needed, the number of visits allowed, and date of expiration that their office has authorized on your behalf.

3. Please remember that your insurance payments to this office may not be 100%. Oftentimes there is patient responsibility in the form of deductible and / or co-insurance amounts. (Some insurers pay fixed allowances for certain procedures and others pay a percentage of the charges. It is your responsibility to pay any deductible and / or co-insurance amounts and / or any other balances not paid by your insurance carrier such as co-payments.

4. In order to control our billing costs, **any unpaid balance that exceed 90 days or more will be assigned to the attorney for collections**. The patient and / or guarantor will be held responsible for any attorney fees, costs for collections, court costs and interest from the date of service.

****

I have read the above financial policy and understand my financial responsibilities to the practice.

Patient/Guardian Signature: ____ Date: ___________________

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Acknowledgement of Notice of Privacy Practices

Today's Date: ______________________________ Is Patient a Minor? ___No ___Yes

Patient Name: ____ Date of Birth: _______________

PRIVATE HEALTH INFORMATION (PHI) TO BE DISCLOSED

____Release information as described in the Notice of Privacy Practices.

____ I allow the following individuals to speak to you / obtain information about my medical condition:

FULL NAME OF INDIVIDUAL (not including your medical doctors) Relationship

____

____

____

Please tell us about any restrictions you have on the release of information to the above listed people: ______

____

____

TERM

This information will remain in effect from the above date and will remain in force unless I submit a change request in writing.

PATIENT ACKNOWLEDGEMENT

I acknowledge that I have been given the opportunity to review the Notice of Practices detailing how my health information may be used and disclosed as permitted under federal and state law and outlining my rights regarding my health information. If patient is a minor, or otherwise unable to sign, an authorized representative should sign below.

____ ____

Patient Signature (or Authorized Representative) PRINT NAME (if Authorized Representative)

Relationship to Patient (If Authorized Representative) ____

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Medical History Assessment

NAME____ **DATE**______________________

AGE____________ **SEX**: __Male ___Female

Reason For Today's Visit: __Total Body Skin Check __Problem: (Describe) ________________________________

HPI: History of Today's Problem(s):

LOCATION (skin area(s) involved) ____

DURATION (how long has problem been present?) ______Days ______Weeks (s) _______Month (s) _______ Year (s)

TIMING (was there any previous treatment?) ___ No ____Yes : When? ______________________________

CONTEXT (was a biopsy done?) _____No _____ Yes : If yes, by whom: ______________________________

Check all that apply regarding today's problem:

Quality	**Modifying Factors**	**Associated Symptom**	**Severity**
A change in:	***A history of:***		
☐ size	☐ x-ray treatment	☐ bleeding	☐ no symptoms
☐ color	☐ ultraviolet light treatment	☐ tingling/pain	☐ occasional symptoms
☐ elevation	☐ arsenic exposure	☐ ulceration	☐ constant symptoms
☐ hardness	☐ chronic scar	☐ infection	
	☐ immunosuppression	☐ itching	

Are you ALLERGIC to any medications? ☐ Yes ☐ No If yes, list:

1.________________________ 2.________________________

3.________________________ 4.________________________

List all medications you are currently taking:

1.________________________ 2.________________________

3.________________________ 4.________________________

Check all that apply regarding your overall health and add any other important information:

Skin
- ☐ normal
- ☐ keloids
- ☐ poor healing
- ☐ skin problems

Hematologic Lymphatic
- ☐ normal
- ☐ anemia
- ☐ bleeding problem
- ☐ enlarged lymph nodes

Constitutional Symptoms
- ☐ none
- ☐ weigh loss
- ☐ fever
- ☐ other

Eyes/Ears/Nose/Throat
- ☐ normal
- ☐ glaucoma
- ☐ hearing aid
- ☐ plastic surgery

Cardiovascular
- ☐ normal
- ☐ angina
- ☐ artificial heart valve
- ☐ pacemaker
- ☐ hypertension
- ☐ Heart attack: When: ______________

Respiratory
- ☐ normal
- ☐ asthma
- ☐ emphysema
- ☐ other lung problem

Gastro-intestinal
- ☐ normal
- ☐ stomach ulcer
- ☐ colitis
- ☐ other GI problem

Musculoskeletal
- ☐ normal
- ☐ arthritis
- ☐ artificial joint
- ☐ other________

****SEE NEXT PAGE!!**

Neurological
- ☐ normal
- ☐ stroke
- ☐ seizures

Psychiatric
- ☐ normal
- ☐ depression
- ☐ anxiety attacks

Endocrine
- ☐ normal
- ☐ diabetes
- ☐ thyroid problem

Infections
- ☐ none
- ☐ hepatitis
- ☐ HIV/AIDS
- ☐ tuberculosis (T.B.)

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Medical History Assessment, Page 2

NAME____ **DATE**____________________________

PATIENT ACCT #____________________

Other Important Medical Information: ____

____

Past Medical History (check answer)

Previous Skin Cancer? ☐ Yes ☐ No

Major Illnesses or Hospitalizations? ☐ Yes ☐ No If Yes, List____

____

Family History (skin cancer):

☐ melanoma ☐ basal cell or squamous cell ☐ No history

Social History: (check answer)

Do you wear glasses? ☐ Yes ☐ No Dentures? ☐ Yes ☐ No Contact lenses? ☐ Yes ☐ No

Do you smoke? ☐ No ☐ Yes If yes, how many packs per day?___________________

If you are a former smoker when did you stop? ___________________________

Do you consume alcohol? ☐ Yes - Socially or Regularly (circle response) ☐ No ☐ Never

Alcohol or drug problems? ☐ Yes ☐ No Addictions? ☐ Yes ☐ No If yes, describe______________________

Other Services (Below is a list of cosmetic services we provide. Please check any one you would like to discuss.):

☐ Blepharoplasty	☐ Glycolic Peel	☐ Micro Dermabrasion	☐ Sclerotherapy	☐ Tattoe Removal
☐ Botox	☐ Hair Laser	☐ Perlane	☐ Sculptra	☐ Thermage (Skin Tightening)
☐ Collagen	☐ Juvaderm	☐ Radiesse	☐ Silicone Injections	☐ No Interest
☐ Fat Transfer	☐ Liposuction	☐ Restylane	☐ Skin Rejuvenation	

May we leave a message on your answering machine? ☐ YES ☐ NO If Yes: Please Write your BEST contact number:

____ This is my: __Work __Cell __Home

May we leave a message at your place of employment? ☐ YES ☐ NO

____

PATIENT SIGNATURE

****
(For office use)

REVIEWED BY: ____ **(Staff Person)**

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PATIENT NAME____ **DATE**: _____________________

PATIENT ACCT #___________________ ***To Be Completed By Practitioner**

***BODY AREAS** ***ABNORMALITIES**

HEAD normal ________________________________
NECK normal ________________________________
CHEST/AXILLA normal ________________________________
BACK normal ________________________________
ABDOMEN normal ________________________________
GROIN/BUTTOCKS normal ________________________________
EXTREMITIES normal ________________________________

***ORGAN SYSTEMS**

SKIN normal ________________________________
EYES normal ________________________________
ENT normal ________________________________
CARDIOVASCULAR normal ________________________________
PULMONARY normal ________________________________
GI normal ________________________________
GU normal ________________________________
MUSCULOSKELETAL normal ________________________________
NEUROLOGIC normal ________________________________
PSYCH/mental status normal ________________________________
LYMPHATIC normal ________________________________
BP_______/_________ HR________ per minute

***ASSESSMENT:**

Pathology: ___ Reviewed Outside Reports **Diagnosis**________________________ **Site(s)**___________________________

Reviewed By: **___Ariel Ostad, MD ___Lisa Pitter, RPA-C ___Emily Isenberg, RPA-C**

____
SIGNATURE OF PRACTITIONER