Laser & Skin Surgery Center of New York®

PATIENT REGISTRATION INFORMATION **TODAY'S DATE:** ____/____/______

Last Name	First Name		MI
Date of Birth	Sex □ Male □ Female		□ Single □ Married □ Divorced □ Widow
Patient Address			Apt.
City, State, Zip			Email:
Home Phone	Cell Phone		Work Phone
Employer	Address		Occupation
Person Responsible for Payment (if other than patient)	Name:		Relationship:
Address: (if different)		Date of Birth:	Phone #:

INSURANCE INFORMATION (COMPLETE ONLY IF POLICYHOLDER IS DIFFERENT THAN THE PATIENT)

Insurance Company Name:	Policy ID #:
Name Of Policy Holder:	DOB Of Policy Holder:

REFERRAL INFORMATION: If referred by a physician, please enter the following:

Name of Physician: ______________________________ Phone #: ______________________

Address of Physician: ______________________________

____

IF NOT REFERRED BY A PHYSICIAN, HOW DID YOU HEAR ABOUT OUR PRACTICE? (please specify)

□ Friend/Family: ____________________ □ Website: ____________________

□ Newsletter □ Other: ____________________

PRIMARY CARE PHYSICIAN INFORMATION:

Physician's Name: ______________________________

Phone #: ____________________

Address: ______________________________

____

WHO SHOULD WE CALL IN CASE OF AN EMERGENCY?

Name: ______________________________ Relationship: ______________________

Home Phone: ____________________ Work Phone: ____________________ Cell Phone: ____________________

Please provide the name(s) of person(s) you would like your medical information released/provided to:

____

LASER & SKIN SURGERY CENTER OF NEW YORK PHYSICIANS FINANCIAL POLICY

PHARMACY INFORMATION AND HIPAA PRIVACY & NOTIFICATION

Thank you for choosing the physicians at the Laser & Skin Surgery Center of New York for your health-care needs.

The following is our payment policy which we require you to read and sign prior to your visit (s).

Patients have many different types of insurance and payment options for services rendered. Also, not all physicians in the practice accept the same type of insurance. To ensure that we have accurate information to process your claim, we will make a copy of your medical insurance and/or Medicare card at the time of your appointment.

You are required to inform us immediately of any changes in demographic information or medical insurance information. Patients without medical insurance are required to pay in full at the time of service.

PARTICIPATING PLANS

You must present your insurance card, and if applicable, your insurance referral form, at every visit. We will submit bills directly to your insurance company for payment on your behalf. Patients without insurance cards or proper referrals will be asked for full payment at the time of service. All co-pays, deductibles and non-covered services will be collected at the time of service. Some insurance plans may send payments directly to you. If you receive payments for the services received, you are responsible for forwarding the check to The Laser & Skin Surgery Center of New York.

NON-PARTICIPATING PLANS

If your provider does not participate in your insurance plan, you are responsible for payment of all charges at the time of service. We will provide you with a receipt that you can submit directly to your insurance carrier.

COSMETIC SERVICES / NON-MEDICALLY NECESSARY SERVICES

Payment in full is due at the time of service for the consultation and all non-medically necessary services and/or cosmetic services. The consultation fee is $400/$450 in addition to all bills for services rendered.

USUAL AND CUSTOMARY RATES

Your insurance policy is a contract between you and your insurance company. Our practice is committed to providing the best treatment and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

COLLECTION ACCOUNTS

For all accounts with balances that are submitted to our collection agency for collection, you will be responsible for all legal and court fees as well as an additional fee of $25.00 for submission to our collection agency.

PAYMENT

For your convenience, the following payment methods are accepted: CASH, PERSONAL CHECK (for established patients only), VISA, MASTERCARD, AMERICAN EXPRESS, and DISCOVER

I have read the policy, I understand and agree to it.

____

(Signature of the Patient or Responsible Party) *(Date)*

____

(Please Print the Name of the Patient)

PHARMACY INFORMATION

NAME OF PHARMACY: ______________________________

ADDRESS: ______________________________

____

TELEPHONE NUMBER: ______________

My signature below acknowledges that I understand that all prescriptions are e-prescribed.

HIPAA PRIVACY NOTICE

My signature below signifies that I have read, reviewed and have been offered a copy of the HIPAA privacy notice.

NOTIFICATION

My signature below acknowledges that it is the office policy not to testify in court, depositions, arbitrations, etc. relating to Worker's Compensation and other personal injury action.

______________________________ Patient Signature

______________ Today's Date

Medical History Information (*for patients who did not access the portal*)

Patient Name: ______________________ A/C#:______________ Date: ________________

Medical History: Please place an "x" in the box provided for conditions you currently have

☐ Anxiety	☐ Breast Cancer	☐ End Stage Renal Disease	☐ Hypercholesterolemia (High Cholesterol)	☐ Prostate Cancer
☐ Arthritis	☐ Colon Cancer	☐ GERD (Acid Reflux)	☐ Hyperthyroidism (Over Active)	☐ Radiation Treatment
☐ Asthma	☐ COPD	☐ Hearing Loss	☐ Hypothyroidism (Under Active)	☐ Seizures
☐ Artrial Fibrillation (Irregular Heartbeat)	☐ Coronary Artery Disease	☐ Hepatitis	☐ Leukemia	☐ Stroke
☐ Bone Marrow Transplantation	☐ Depression	☐ Hypertension (High Blood Pressure)	☐ Lung Cancer	☐ Other
☐ BPH	☐ Diabetes	☐ HIV/AIDS	☐ Lymphoma	☐ None

Past Surgeries: Please place an "X" in the box provided for any past surgeries you have had

☐ Appendix (Appendectomy)	☐ Gallbladder (Cholecystectomy)	☐ Kidney: Kidney Stone Removal	☐ Ovaries Tubal Ligation	☐ Skin: Skin Biopsy
☐ Bladder (Cystectomy)	☐ Heart: Biological Valve Replacement	☐ Kidney: Kidney Transplant	☐ Pancreas: Pancreatectomy	☐ Skin: Squamous Cell Carcinoma
☐ Breast Biopsy	☐ Heart: Coronary Artery Bypass Surgery	☐ Kidney: Nephrectomy	☐ Prostate (Prostatectomy) Prostate Biopsy	☐ Spleen Splenectomy
☐ Breast: Lumpectomy Right / Left / Both	☐ Heart: Heart Transplant	☐ Liver: Hepatectomy	☐ Prostate (Prostatectomy) Prostate Cancer	☐ Testicles: Orchiectomy
☐ Breast: Mastectomy Right / Left / Both	☐ Heart: Mechanical Valve Replacement	☐ Liver: Liver Transplant	☐ Prostate (Prostatectomy) TURP	☐ Uterus (Hysterectomy): Fibroids
☐ Colon (Colectomy) Colon Cancer Resection	☐ Heart: PTCA	☐ Liver: Shunt	☐ Rectum: APR	☐ Uterus (Hysterectomy): Uterine Cancer
☐ Colon (Colectomy) Diverticulitis	☐ Joint Replacement: Hip Right / Left / Both	☐ Ovaries (Oophorectomy): Endometriosis	☐ Rectum: Low Anterior Resection	☐ Uterus (Hysterectomy): Cervical Cancer
☐ Colon (colectomy) Inflammatory Bowel Disease	☐ Joint Replacement: Knee Right / Left / Both	☐ Ovaries (Oophorectomy): Ovarian Cancer	☐ Skin: Basal Cell Carcinoma	☐ None
☐ Colon Colostomy	☐ Kidney: Kidney Biopsy	☐ Ovaries (Oophorectomy): Ovarian Cyst	☐ Skin: Melanoma	

Skin Disease History: Please place an "X" in the box provided for any condition you may have

☐ Acne	☐ Basal Cell Skin Cancer	☐ Eczema	☐ Poison Ivy	☐ Squamous Cell cancer
☐ Actinic Keratosis	☐ Blistering Sunburns	☐ Hay Fever/Allergies	☐ Precancerous Lesion	☐ Other
☐ Asthma	☐ Dry Skin	☐ Melanoma	☐ Psoriasis	☐ None

Family History of Melanoma: Do you have a family history of Melanoma? ☐ NO **If yes, which relative?**

☐ Mother ☐ Father	☐ Brother ☐ Sister	☐ Grandmother ☐ Grandfather	☐ Grandson ☐ Granddaughter	☐ Niece/Nephew
☐ Daughter ☐ Son	☐ Aunt ☐ Uncle	☐ Other: Specify:		

)o you wear Sunscreen? If yes, What SPF ___________ Do you tan in a tanning salon? ☐ Yes or ☐ No

SOCIAL HISTORY:

Tobacco Use Screening

☐ Never Smoker	☐ Current every day smoker	☐ Former Smoker

Alcohol Use Screening

☐ None	☐ Less than 1 drink per day	☐ 1-2 drinks per day	☐ 3 or more drinks per day

WOMEN ONLY: In the past year have you had more than 4 drinks in 1 day? If yes, how many? _______
MEN ONLY: In the past year have you had more than 5 drinks in 1 day? If yes, how many? _______
65 OR OLDER: In the past year have you had more than 5 drinks in 1 day? If yes, how many? _______

Are you pregnant? ☐ Yes or ☐ No **Are you trying to get pregnant?** ☐ Yes or ☐ No
Do you have a pacemaker/defibrillator? ☐ Yes or ☐ No
Height: _____ft _____inches Weight: _______lbs

HAVE YOU HAD A FLU VACCINE? ☐ Yes ☐ No
HAVE YOU HAD A PNEUMONIA VACCINE? ☐ Yes ☐ No

DO YOU TAKE MEDICATION? ☐ Yes ☐ No (If yes, please list, including over-the-counter medications)

Name of Medication	Dosage/Strength	How often do you take medication?
1. ____________	____________	____________
2. ____________	____________	____________
3. ____________	____________	____________
4. ____________	____________	____________
5. ____________	____________	____________

Do you have allergies? ☐ Yes (if yes, please list) ☐ **NO ALLERGIES**

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o be completed by clinical personnel:

For Mohs Consults ONLY:
BP: ______/______