DOUGLASTON DERMATOLOGY

Yasemin Osman, M.D., PLLC
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Keriann Giacomazza, PA-C
60-40 Marathon Parkway
Douglaston, NY 11362

Patient Information

Name: ____________________ **Home phone:** ____________________

Cell Phone: ____________________ **Work Phone:** ____________________

Email address: (required) ____________________

Address: ____________________ **Apt#** ________

City: ____________________ **State:** ________ **ZIP:** ________

Date of Birth: ____________ **SS#:** _______-_______-_______ **Sex:** ________

Marital Status: Single ________ **Married** ________ **Other** ________

Employer: ____________________ **Address** ____________________

Primary Care Doctor: ____________________ **Phone #** ____________________

Referred By: Doctor ____ **Relative** ____ **Other Patient** ____ **Insurance Book** ____ **Ad** ____

Name ____________________ **Phone #** ____________________

Pharmacy Name: ____________________ **Pharmacy Address:** ____________________

Pharmacy Phone# ____________________ ____________________

Insurance Policy Holder Information

Name of Insurance: ____________________ **Referral Needed Y** ____ **N** ____

Name of Policy Holder: ____________________ **Date Of Birth:** ____________

Sex: M ____ **F** ____ **SS#** _______-_______-_______ **Relation to you:** ____________

Address if different then above: ____________________ **Apt#** ________

City ____________________ **State** ____________ **ZipCode** ____________

I authorize Douglaston Dermatology to furnish all records pertaining to the medical history, service rendered or treatments given to me or my dependent for purpose of insurance claims reviews. I authorize payment of medical benefits to my physician and I accept financial responsibility for services not paid by my insurance including deductibles, co-payments, non-covered services, and any fees not paid by my insurance (for any reason) within 120 days of the date of service.

Patient or Authorized Signature: ____________________ **Date:** ____________

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Patient Name:____________________ **Sex:** Male Female

Home Phone:__________ **Cell Phone:**__________ **Pharmacy Phone:** __________

Allergies to Medications: None 1. __________ Reaction __________
2. __________ Reaction __________

Current Medications: None 1. __________ 3. __________
2. __________ 4. __________

	Yes	No		Yes	No		Yes	No
Aspirin/Motrin/Advil	☐	☐	Birth Control Pills	☐	☐	Are you Pregnant	☐	☐
Coumadin	☐	☐	Are you breast feeding	☐	☐	Plan on becoming pregnant	☐	☐

Reviews of System (Current or past problems with)

	Yes	No		Yes	No		Yes	No
Blood/bleeding disorders	☐	☐	Arthritis	☐	☐	Cancer (non-skin)	☐	☐
Heart Disease	☐	☐	Diabetes (Sugar)	☐	☐	Immunologic Disease	☐	☐
Kidney Disease	☐	☐	High Blood Pressure	☐	☐	Latex/Rubber/Nickel/Food	☐	☐
Liver Disease or Hepatitis	☐	☐	Infectious Disease (TB, HIV)	☐	☐	Skin Disease	☐	☐
Lung Disease	☐	☐	Received Blood Transfusions	☐	☐	Skin Cancer	☐	☐
Thyroid Disease	☐	☐	Psychological Disorders	☐	☐	Melanoma	☐	☐

Do you	Yes	No		Yes	No
Have a pacemaker or defibrillator	☐	☐	Have an artificial joint or heart valve	☐	☐
Take antibiotics prior to surgical procedures	☐	☐	Form Keloids?	☐	☐

List Surgeries:
1.__________ 3. __________ 5. __________
2.__________ 4. __________ 6. __________

Family History (Check the following medical conditions which have occurred in your family)

Disease	Mother	Father	Blood Relative	Disease	Mother	Father	Blood Relative
Acne	☐	☐	☐	Hay Fever	☐	☐	☐
Arthritis	☐	☐	☐	Hives	☐	☐	☐
Asthma	☐	☐	☐	Lupus	☐	☐	☐
Cancer	☐	☐	☐	Melanoma	☐	☐	☐
Diabetes	☐	☐	☐	Psoriasis	☐	☐	☐
Eczema	☐	☐	☐	Skin Cancer	☐	☐	☐

Social History

	Yes	No	
Do you live alone?	☐	☐	
Do you drink alcohol?	☐	☐	Frequency __________
Do you use recreational drugs?	☐	☐	Frequency __________

Occupation: __________ **Hobbies/leisure activity**: __________

Patient signature: __________ **Date:** __________

Reviewed by: __________ **Date:** __________

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TO ALL OUR INSURANCE PATIENTS

In an effort to keep your personal expenses down we are accepting assignment. **However this means:**

1. You must be eligible for the benefit.

2. Co-payment must be made by the patient at the time of visit.

3. If required, a referral or authorization of consent from your primary care physician (GP, Internist, Etc.) must be on file before you are examined or treated.

4. You, the patient, are responsible to obtain your referrals. If a referral is not obtained, you the patient will be responsible for payment in full.

5. You are responsible for payment of all deductibles as well as, any co-insurance payments due

6. If you have a high deductible plan, you are responsible for all charges incurred prior to meeting your deductible and any co-payments and co-insurances thereafter. These are the conditions of your policy that are chosen by you and your employer.

7. As a patient I agree that I will pay my deductible to the office and that if co-payment or co-insurance comes directly to me I will send this balance to the office.

8. I further agree that if the insurance company refuses to pay, that I am responsible and will pay the fees for services rendered in this office.

I hereby agree to all the terms and conditions set forth above.

____
Patient/Legal Guardian Name (Print)

____
Signature

____
Date

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NOTICE TO OUR PATIENTS

Under HIPPA REGULATIONS I need to give the Doctor permission to discuss my medical condition with

NAME OF INDIVIDUAL	RELATIONSHIP TO YOU
SIGNATURE OF PATIENT	DATE

Douglaston Dermatology

Receipt of Notice of Privacy Practices

Notice to patient:

We are required to advise you of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. By signing below, you acknowledge that you have received our Notice of Privacy Practices.

☐ Received Physical Copy ☐ Waived Physical Copy

____

Patient's name Patient's Date of Birth

____

Personal Representative name Relationship to Patient

____

Signature Date

For Office Use Only

In the case that written acknowledgement could not be obtained, please select reason below.

___ Patient/Personal Representative refused to sign.

___ Patient/Personal Representative was unable to sign.

___ The Patient had a medical emergency and an attempt to obtain the acknowledgment will be made at the next available opportunity.

___ Other reason (please specify): ______________________________

____

______________________________ ______________

Signature of Workforce Member Completing Form Date