Douglaston Dermatology
Yasemin Osman, M.D. , PLLC
Fiona Pasternack Blanco, M.D.
60-40 Marathon Parkway
Douglaston, New York 11362
Ph# (718) 631-3778 Fax# (718) 281-2055
Email: staff@douglastonderm.com

Patient Information

Name:______________________ Date of Birth:______________
Cell Phone#:______________ Home Phone#:______________
Email Address (required):______________________________
Home Address:______________________ Apt #:________
City#:______________ State:________ Zip Code #:________

What is your current gender identity?
☐ Male ☐ Female ☐ Non-Binary ☐ Transgender Male/Transman/FTM
☐ Transgender Female/Transwoman/MTF ☐ Decline to Answer
What sex were you assigned at birth? ☐ Male ☐ Female ☐ Other
What pronouns do you prefer that we use when talking about you? ☐ She/her/hers ☐ He/him/his ☐ They/them/theirs
☐ Other:____________

Marital Status: Single:__________ Married:__________ Other:______________
Employer:______________________ Address:______________________
Primary Care Doctor:______________________ Phone#:______________
Referred By (Name and Phone):
Doctor:______________ Relative:______________ Patient:______________ Other:________

Pharmacy Name:______________________ Pharmacy Address:______________________
Pharmacy Phone#:______________

Insurance Policy Holder Information

Name of Insurance:______________________ Referral Needed: Yes______ No________
Name of Policy Holder:______________ Date of Birth:______________
Relation to You:____________ Address of Policy Holder:______________

I authorize Douglaston Dermatology to furnish all records pertaining to the medical history, service rendered or treatments given to me or my dependent for insurance claim reviews. I authorize payment of medical benefits to my physician and I accept financial responsibility for services not paid by my insurance including deductible, co-payments, non-covered services, and fees paid by my insurance (for any reason 0 within 120 days of the date of service).

Patient or Authorized Signature:______________ Date:__________

DOUGLASTON DERMATOLOGY

Yasemin Osman, M.D., PLLC
Fiona Pasternack Blanco, M.D.

60-40 Marathon Parkway
Douglaston, NY 11362

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:** ____________

Douglaston Dermatology
Yasemin Osman, MD. PLLC.
Fiona Blanco, MD.
60-40 Marathon Parkway
Douglaston, NY 11362
(718) 631-3778 Fax (718) 281-2055

NOTICE TO OUR PATIENTS

If your insurance plans (most HMO'S) require a referral from your Primary Care Physician, it is your responsibility to bring in a VALID UNEXPIRED referral. No exceptions will be made.

If you have a plan that we do not participate with, YOU MAY GO OUT OF NETWORK, but you will be responsible for your deductibles, co-insurance, and any services not covered within your plan.

Douglaston Dermatology requires a 24-hour notice for appointment cancellations. There is a fee of $50.00 for medical appointments that are missed and/or not cancelled within 24 hours. There is a fee of $150.00 for missed or not cancelled cosmetic appointments. This fee must be paid before rescheduling the missed appointment.

Douglaston Dermatology reserves the right to modify the privacy practices outlined in the notice.
I have received a copy of the Notice of Privacy Practices for Douglaston Dermatology.

________________ ________________ __________

PRINT NAME SIGNATURE DATE

____

SIGNATURE OFGUARDIAN IF UNDER 18

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

Yasemin Osman, M.D., PLLC
Fiona Pasternack Blanco, M.D.

60-40 Marathon Parkway
Douglaston, NY 11362

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

DOUGLASTON DERMATOLOGY

Yasemin Osman, M.D., PLLC
Fiona Pasternack Blanco, M.D.
60-40 Marathon Parkway
Douglaston, NY 11362
Phone (718) 631-3778 Fax (718) 281-2055
Email: staff@douglastonderm.com

Receipt of Notice of Privacy Practices

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