MARCY A. GOLDSTEIN, M.D.

Patient Registration and Health Questionnaire

PATIENT INFORMATION

Date ____________ Soc. Sec. # ____________ Date of Birth ____________

Name ____
(Last Name) (First Name) (Initial)

Address ____________ City ____________ State ______ Zip ______

Home Phone ____________ Cell Phone ____________

Sex: ( )M ( )F Marital Status: ( )Single ( )Married ( )Divorced ( )Widowed ( )Separated ( )Minor

Employer ____________ Occupation ____________

Business Address ____________ Business Phone ____________

Spouse's Name ____________ If Under 18 Parent/Guardian ____________

Emergency Contact ____________ Phone ____________ Relationship ____________

Referred By? EMail:

PRIMARY INSURANCE

Person Responsible for Account (cardholder) ____________

Relationship to Patient ____________ Date of Birth ____________ Soc. Sec. # ____________

Address ____________ City ____________ State ______ Zip ______

Home Phone ____________ Business Phone ____________ Cell Phone ____________

Insurance Company and Address ____________

Subscriber I.D. # Group #

ADDITIONAL INSURANCE

Insured Name ____________

Relationship to Patient ____________ Date of Birth ____________ Soc. Sec. # ____________

Address ____________ City ____________ State ______ Zip ______

Home Phone ____________ Business Phone ____________ Cell Phone ____________

Insurance Company and Address ____________

Subscriber I.D.# ____________ Group # ____________

I hereby authorize direct payment of surgical/medical benefits to Dr. Marcy Goldstein for services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance. I hereby certify that the information given by me is correct. A photocopy of these assignments shall be as valid as the original.

Patient Name (please print) ____________

Parent/Guardian (please print) ____________

Signature ____________ Date ____________

HIPAA COMPLIANT

21st Century Dermatology, LLC
1 West Ridgewood Avenue, Ste 305
Paramus, NJ 07652
Phone: (201) 445-8786
Fax: (201) 445-8811

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY)

( ) Home Telephone ______________________

( ) Work Telephone ______________________

( ) Cell Telephone ______________________

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( ) OK to leave message with detailed information

( ) OK to leave message with family member

( ) Leave message with a call-back number ONLY

ACKNOWLEDGEMENT SIGNATURE FORM

I have received the Notice of Privacy and Disclosures Forms and I have been provided an opportunity to review it.

Patient's Name______________________________________

Signature______________________________________

Date______________________________________

21st Century Dermatology, LLC
1 West Ridgewood Avenue, Ste 305
Paramus, NJ .07652.
(201) 445-8786
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To: Our Patients

Effective immediately, our office will no longer be balance billing via paper invoices for co-insurances, deductibles or copay differences.

This is a safe and time efficient way to reduce account receivable expenses and also saving on envelopes and stamps which would be beneficial to both parties.

Your credit card information will be kept in a secure place and will only be used for balances on your account AFTER the insurance company has finalized the claim.

Copays are due at the time of your visit and will be collected at that time.

Sincerely,
21st Century Dermatology, LLC

I authorize 21st Century Dermatology, LLC to charge outstanding balances on my account to the following credit card:

Visa   Mastercard   American Express   Discover

Account Number ______________________________ Exp Date ___________

Name on Card (please print) ____

Signature ______________________________ Date _______________________

Past Medical History

- Anxiety
- Asthma
- Bone Marrow Transplantation
- Breast Cancer
- COPD
- Depression
- End Stage Renal Disease
- Hearing Loss
- Hypertension
- Hypercholesterolemia
- Hypothyroidism
- Lung Cancer
- Prostate Cancer
- Seizures
- Other
- Arthritis
- Atrial Fibrillation (Irregular Heartbeat)
- BPH
- Colon Cancer
- Coronary Artery Disease
- Diabetes
- GERD
- Hepatitis
- HIV / AIDS
- Hyperthyroidism
- Leukemia
- Lymphoma
- Radiation Treatment
- Stroke
- **None**

Past Surgeries

- Appendix (Appendectomy)
- Breast : Mastectomy (Right, Left, Bilateral)
- Breast : Breast Biopsy
- Breast : Breast Implants
- Colon (Colectomy) : Diverticulitis
- Gallbladder (Cholecystectomy)
- Heart : PTCA
- Heart : Biological Valve Replacement
- Joint Replacement : Knee (Right, Left, Bilateral)
- Kidney : Kidney Biopsy
- Kidney : Kidney Stone Removal
- Ovaries (Oophorectomy) : Endometriosis
- Ovaries (Oophorectomy) : Ovarian Cancer
- Prostate (Prostatectomy) : Prostate Biopsy
- Skin : Skin Biopsy
- Skin : Squamous Cell Carcinoma
- Spleen (Splenectomy)
- Uterus (Hysterectomy) : Fibroids
- Other
- Bladder (Cystectomy)
- Breast : Lumpectomy (Right, Left, Bilateral)
- Breast : Breast Reduction
- Colon (Colectomy):Colon Cancer Resection
- Colon (Colectomy) : IBD
- Heart : Coronary Artery Bypass Surgery
- Heart : Mechanical Valve Replacement
- Heart : Heart Transplant
- Joint Replacement : Hip (Right, Left, Both)
- Kidney : Nephrectomy
- Kidney : Kidney Transplant
- Ovaries (Oophorectomy) : Ovarian Cyst
- Prostate (Prostatectomy) : Prostate Cancer
- Prostate (Prostatectomy) : TURP
- Skin : Basal Cell Carcinoma
- Skin : Melanoma
- Testicles (Orchiectomy)
- Uterus (Hysterectomy) : Uterine Cancer
- **None**

Name:________________________

SKIN DISEASE HISTORY : (PLEASE CIRCLE ALL THAT APPLY)

ACNE ACTINIC KERATOSIS ASTHMA BASAL CELL CANCER
BLISTERING SUNBURNS DRY SKIN ECZEMA FLAKING OR ITCHY SCALP
HAYFEVER/ALLERGIES MELANOMA POISON IVY PRECANCEROUS MOLES
PSORIASIS SQUAMOUS CELL SKIN CANCER NONE

OTHER ____________________

DO YOU WEAR SUNSCREEN? YES NO
IF YES, WHAT SPF? ____________________
DO YOU TAN IN A TANNING SALON? YES NO

DO YOU HAVE A FAMILY HISTORY OF MELANOMA? YES NO
IF YES, WHICH RELATIVE (S)? ____________________

ANY OTHER FAMILY HISTORY: ____________________

MEDICATIONS (PLEASE ENTER ALL CURRENT MEDICATIONS)

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ALLERGIES: ____________________

SOCIAL HISTORY : (PLEASE CIRCLE ALL THAT APPLY)

CIGARETTE SMOKING: NEVER SMOKED - QUIT - FORMER SMOKER
SMOKES LESS THAN DAILY - SMOKES DAILY

RACE & ETHNIC GROUP - WHITE, AMERICAN INDIAN OR ALASKA NATIVE, ASIAN, BLACK OR AFRICAN AMERICAN, NATIVE HAWAIIAN OR PACIFIC ISLANDER, OTHER

PREFERRED LANGUAGE ____________________

PHARMACY NAME: ____________________
PHONE # ____________________