TURNER DERMATOLOGY

59 EAST 54TH STREET, SUITE 3 NEW YORK, NY 10022
T: (212)644-8581 F: (212)644-8583 E: info@turnerdermatology.com
TURNERDERMATOLOGY.COM

Patient Information Sheet

Date:

Name:__________________ Middle Name:__________________ Last Name:__________________

Sex: ______ Date of Birth: Marital Status:__________________

Address:________________________________ Apt:_______ Zip :__________

City: __________________ State:______________

Telephone (home): __________________ (work): __________________ (cell): __________________

Email:____

Emergency Contact:__________________ *Relationship:*__________*Telephone:*__________________

Name of Employer:________________________________ Occupation:__________________________

How did you hear about us?:____

Referring physician:____

Primary Insurance Name:_________________________ Subscriber name:_________________________

Relationship to Patient (check one): Self Spouse Dependent

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

Race: American Indian/Alaskan Native Black/African American Asian

Native Hawaiian/Other Pacific Islander White Other Race

59 EAST 54TH STREET, SUITE 3 NEW YORK, NY 10022
T: (212)644-8581 F: (212)644-8583 E: info@turnerdermatology.com
TURNERDERMATOLOGY.COM

Consents

Authorization of Assignment and Release

I authorize payment of medical insurance benefits to be made on my behalf to Turner Dermatology for any services provided to me by Turner Dermatology. I authorize release of any information needed to process the claim.

Financial Agreement

Insurance Claims - I certify that the insurance information I have provided is accurate. Insurance claim submission is provided for accepted insurances. I am responsible for all copayments, coinsurances, deductible amounts and past balances at the time of service. I understand that if my insurance is determined to be out-of-network and/or I have chosen an out-of-network visit and I have services provided, or if I have declined a required referral for my visit, or that I chose to be self-pay, that I agree to be responsible for payment for the total services provided.

Balance Collections - I understand that statement balances are due within 30 days of receipt. I agree to pay a $20.00 fee for any check that bounces due to insufficient funds or is returned. In the event of default, the balance of my account will be forwarded to a collection agency and I agree to pay all costs but not limited to collection fees, court costs, or attorney fees.

Medical Cancellation/No Show Policy - I understand that appointments not canceled with 48 hours notice will be subject to a $50.00 fee.

Aesthetics & Cosmetics Cancellation/No Show Policy - I understand that appointments not canceled with 48 hours notice will be subject to a 20% charge of the intended procedure cost. After one no show or cancellation, future visits will require a $100 deposit. The deposit will be credited to charges incurred at the scheduled visit or may be forfeited if the cancellation policy is violated.

Email and phone consent

With respect to any services provided or that are planned to be provided to myself or, as an authorized legal representative, fully consent to and authorize RYAN TURNER/ DBA TURNER DERMATOLOGY, RYAN TURNER, 59 EAST 54TH ST 3 NEW YORK, NY 10022-4211 or any of its automated systems to contact me via phone (including to my cellular phone by way of phone call or text message) in relation to any services received from Healthcare Provider or any services planned to be received from Healthcare Provider (including any billing items or appointment reminders).

Signature: Date:___________________

TURNER DERMATOLOGY

59 EAST 54TH STREET, SUITE 3 NEW YORK, NY 10022
T: (212)644-8581 F: (212)644-8583 E: info@turnerdermatology.com
TURNERDERMATOLOGY.COM

Patient Information Sheet

Name:__________________ Middle Name:__________________ Last Name:__________________

Reason for today's visit: ____

Past Medical History (check all that apply)

Anxiety
Arthritis
Artificial Joints
Asthma
Atrial Fibrillation
Bone Marrow Transplant
Cancer:__________
COPD
Depression
Diabetes
Kidney Disease
Prostate Disease
Reflux
Hepatitis
High Blood Pressure
HIV/AIDS
High Cholesterol
Hyperthyroidism
Heart Disease
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker/AICD
Radiation Therapy
Seizures
Stroke
Skin Disease:__________
Valve replacement

OTHER:__________
NONE

Past Surgical History (check all that apply):

Appendix
Coronary Artery Stents
Prostate Surgery
Mastectomy
Heart Transplant
Skin cancer surgery
Colectomy
Joint Replacement
Testicular surgery
Gallbladder
Kidney Transplant
Uterine Surgery
Coronary Bypass
Ovaries Removed

OTHER:__________
NONE

Do you wear sunscreen?: Do you smoke?: Have you smoked in the past:

History of drug use: Alcohol Use: If yes, how many drinks per/day:________________

Current Medications:____
Allergies:____

Review of Systems (check all that apply):

Bleeding problems
Scarring problems
Rash
Immunosuppression
Hay fever
Chest pain
Fever or Chills
Night sweats
Weight loss
Thyroid problems
Sore throat
Blurred vision
Stomach pain
Bloody Stool
Bloody Urine
Joint pains
Muscle weakness
Neck stiffness
Headaches
Seizures
Cough
Shortness of breath
Wheezing
Anxiety
Depression
OTHER:__________
NONE

Pharmacy name (required): ______________ Pharmacy phone number(required):__________________

59 EAST 54TH STREET, SUITE 3 NEW YORK, NY 10022
T: (212)644-8581 F: (212)644-8583 E: info@turnerdermatology.com
TURNERDERMATOLOGY.COM

Acknowledgement of Receipt of the Notice of Privacy Practices
(You May Refuse To Sign This Acknowledgement)

I, ____, have received a copy of the practice's Notice of Privacy Practices. I understand that Turner Dermatology may use my health information for treatment, payment and health care operations. I understand that Turner Dermatology has the right to change the Notice of Privacy Practices at any time and I can obtain a current copy by contacting the office at (212)-644-8581.

____ Print Name

Signature Patient/Parent/Legal Guardian

____ Date

Privacy notice effective Date: January 1, 2015

For office Use:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Policy but the acknowledgement could not be obtained because:

__Individual refused to sign

__Communications barriers prohibited obtaining the acknowledgment

__Other (Specify)__________________________