LANCE H. BROWN M.D.

NEW YORK
10 West 15th Street, New York, NY 10011
P (212) 924-7546 F (212) 924-7557

EAST HAMPTON
386 Montauk Hwy., P.O. Box 585, Wainscott, NY 11975
P (631) 725-1771 F (631) 725-1888
drlancebrown.com

PATIENT INFORMATION FORM

Today's Date:________________________ (Please show all insurance cards to the front desk)

Patient Name: ____

Street Address: ____

City: ___________________ State: _________________ Zip Code: __________________

Telephone: (H)_______________________ (C)_____________________ (W)______________

Email: ____

Sex: _ Male __ Female Date of Birth: _________________ S.S.#: _______________

Marital Status: ________________ Name of Spouse/Partner: __________________

Emergency Contact: _____________________________ Relationship: _______________

Phone: (H)____________________ (C)____________________ (W)____________________

Are you employed? __ Yes __ No If yes, what is your occupation?______________

Name of employer: ____

Work Address: ____

Who referred you? ____

Insurance Information

What is the name of your PRIMARY insurance company?_____________________________

Name of Insured: (If other then patient)____________________Relationship:____________

Member I.D.#:______________________________ Group #: ____________________

What is the name of your SECONDARY insurance company?__________________________

Name of Insured: (If other then patient)____________________Relationship:____________

Member I.D. #:_____________________________ Group #: ____________________

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Please Read In Its Entirety And Sign Below

I understand that all medical costs incurred by me are my responsibility; including any charges my insurance fails to pay and/or any deductibles or co-insurance that my insurance coverage may have. I also understand that I am responsible for any co-payment or payment of cosmetic procedures on the day of service.

In order to provide the best possible service and availability to all our patients, it is our policy to charge a fee of ($75.00) for any appointments not canceled at least 24 hours prior. If you are having a cosmetic procedure it is our policy to charge a fee of (half the cost) of the procedure for any appointments not canceled at least 24 hours prior. Please call us as early as possible if you know you will need to reschedule your appointment.

I have read and understand the above policies and I agree to be bounded by its items.

Signature of Patient: ________________________________ **Date:** ____________

I authorize payment of medical benefits to the physician for services provided.

Signature of Insured: ________________________________ **Date:** ____________

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HIPAA Privacy Consent

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health Information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: ____
Printed Name – Patient or Representative

Relationship to Patient (if other than patient): ______________________________

Signature: ____

Date: _________________

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Dermatology Medical History

Patient: ______________________________ Date of Birth:: ___/___/___ Today's Date: ___/___/___

Are you allergic to any medications? ❑ YES ❑ NO If yes, list below:
1. ______________________ 2. ______________________

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):
1. ____________ 3. ____________ 5. ____________
2. ____________ 4. ____________ 6. ____________

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	**YES**	**NO**
Bronchitis	❑	❑
Emphysema	❑	❑
Asthma	❑	❑
Chronic Cough	❑	❑
Morning Cough	❑	❑
Shortness of Breath	❑	❑
Wheezing	❑	❑

Cardiovascular:	**YES**	**NO**
High Blood Pressure	❑	❑
Chest Pain	❑	❑
Heart Attack	❑	❑
Heart Murmur	❑	❑
Irregular Heartbeat	❑	❑
Phlebitis	❑	❑
Inflammation of vein	❑	❑
Blood clots	❑	❑
Pacemaker	❑	❑

Other Systemic:	**YES**	**NO**
Diabetes	❑	❑
Excessive thirst/hunger	❑	❑
Amputation	❑	❑
Thyroid	❑	❑
Kidney	❑	❑
Dialysis	❑	❑
Bladder	❑	❑
Frequency/burning	❑	❑
Gastrointestinal		
Stomach absorptive disorder	❑	❑
Nausea, vomiting, diarrhea when taking antibiotics	❑	❑
Yeast infection when taking antibiotics	❑	❑
Arthritis/Joint Deformity	❑	❑
Arthralgia	❑	❑
Limited motion	❑	❑
Artificial joint	❑	❑
Convulsions, Epilepsy or Seizures	❑	❑
Fainting	❑	❑

List any other diseases or conditions: ______________________

List surgical procedures you have had in the last 6 months: ______________________

Skin:
Have you ever had skin cancer? ❑ YES ❑ NO
Has anyone in your family had skin cancer? ❑ YES ❑ NO
Do you have a history of any specific skin diseases? ❑ YES ❑ NO If yes, ____________
Do you have problems with healing ❑ YES ❑ NO
Do you develop keloids (scars) after surgery ❑ YES ❑ NO
Do you bleed easily? ❑ YES ❑ NO
Do you develop skin rashes in reaction to ❑ Medications ❑ Food ❑ Environment ❑ Bandages ❑ Topical Neosporin ❑ Other ______________________

Social History:
Do you drink alcohol? ❑ YES ❑ NO If YES ________ drinks per day
Do you use IV drugs? ❑ YES ❑ NO If YES, what? ____________ How often? ________
Do you smoke? ❑ YES ❑ NO If YES, how much: ____________
Have you had or have you been exposed to HIV (AIDS)? ❑ YES ❑ NO

Please answer the following questions:
(Women) Are you pregnant? ❑ YES ❑ NO Due Date: ___/___/___
What is your occupation? ______________________ Hobbies? ______________________

Completed by: ❑ Patient
❑ Medical Assistant ________ Initials ______________________ Signed by Patient ___/___/___ Date

______________________ Reviewed by ___/___/___ Date

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Office Billing and Insurance Related Policies

Below is a summary of our billing and insurance-related policies, but please familiarize yourself with your insurance carrier's specific requirements. Please note that our office employs a billing service, which communicates with patients and insurance carriers for all billing matters.

1. If your insurance carrier requires you to pay a portion of your healthcare visits (i.e. co pays), we are legally required to collect these and no exceptions will be made. You are required to pay your co pay at the time of your visit.

2. Please confirm whether your insurance carrier requires you to have a referral in order to be seen in our office, so that you can submit the referral at or before your appointment.

3. If your insurance requires you to meet an annual deductible before your healthcare is covered, you will be billed for all services rendered until you meet your deductible.

4. Please leave your credit card information when you check-in at our front desk. This information will be held securely until your insurance carrier has paid its portion and notified us of your share. After the insurance carrier has notified us, we will charge any remaining balance to your credit card. We will mail you a copy of the charge. Please note that this process will not compromise your ability to dispute a charge or your insurance carrier's determination of payment.

I ________________________ (print name) authorize Lance H. Brown, M.D. PLLC to charge outstanding balances to the following credit card.

	Account number	Security Code	Expiration Date
American Express			
MasterCard			
Visa			

Name on Card ______________________________
Signature ______________________________