-DIANE C. MADFES, M.D., P.C
1 East 69th Street
New York, NY 10021

THIS PATIENT INFORMATION FORM IS PART OF YOUR MEDICAL RECORD AND MUST BE COMPLETED IN ITS ENTIRETY

PATIENT INFORMATION FORM

DATE_____/_____/_____ SS#_____-_____-_____ DATE OF BIRTH_____/_____/_____ AGE_____ SEX: M F

PATIENT_____ _____ MARITAL STATUS: S M D W
(Last) (First) (Middle)

HOME ADDRESS: _____ APT # _____

_____
(City) (State) (Zip Code)

HOME PHONE: (_____) _____-_____ CELL PHONE: (_____) _____-_____

WORK PHONE: (_____) _____-_____ OCCUPATION: _____

EMPLOYER NAME: _____

WORK ADDRESS: _____

REFERRED BY: _____

PRIMARY CARE PHYSICIAN: _____ PHONE NUMBER: (_____) _____-_____

ADDRESS: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE NUMBER: (_____) _____-_____

IF MINOR – FINANCIAL INFORMATION

PERSON RESPONSIBLE FOR PAYMENT: _____
(Last) (First) (Middle)

RELATIONSHIP TO PATIENT_____

SS#_____-_____-_____ BIRTHDATE_____/_____/_____

HOME ADDRESS: _____
(City) (State) (Zip Code)

HOME PHONE: (_____) _____-_____ WORK PHONE: (_____) _____-_____

EMPLOYER NAME_____

WORK ADDRESS_____
(City) (State) (Zip Code)

CONSENT FOR PHOTOGRAPHING:

I HEREBY GIVE MY PERMISSION TO MY PHYSICIAN OR ANY ASSISTANT THAT SHE MAY DESIGNATE TO TAKE PHOTOGRAPHS FOR DIAGNOSTIC PURPOSES AND TO ENHACE THE MEDICAL RECORD. I AGREE THAT THESE PHOTOGRAPHS WILL REMAIN IN HER PROPERTY AND SHE MAY USE THEM FOR MEDICAL, SCIENTIFIC OR OTHER PRESENTATIONS AND PUBLICATIONS.

PATIENT NAME (PRINT) _____

SIGNATURE_____ DATE_____

MEDICAL HISTORY: (CHECK ALL THAT APPLY)

YES	NO	
____	____	DUODENAL OR PEPTIC ULCER
____	____	OTHER INTESTINAL DISEASE OR COLITIS
____	____	LIVER OR GALLBLADDER DISEASE
____	____	HEART DISEASE (RHEUMATIC FEVER, PACEMAKER, OTHER)
____	____	HIGH BLOOD PRESSURE
____	____	STROKE
____	____	KIDNEY DISEASE
____	____	URINARY OR BLADDER PROBLEM OR INFECTION
____	____	HEPATITIS A, B, OR C
____	____	HERPES SIMPLEX
____	____	VENEREAL DISEASE
____	____	BLOOD OR LYMPH GLAND DISORDER
____	____	EYE DISEASE (GLAUCOMA, CATARACT, OTHER)
____	____	THROMBOPHLEBITIS
____	____	CANCER
____	____	FREQUENT INFECTIONS (SKIN OR OTHER)
____	____	NEUROLOGICAL DISORDER
____	____	EMOTIONAL OR PSYCHIATRIC PROBLEM
____	____	EXCESSIVE BLEEDING WHEN CUT
____	____	DIFFICULTY WITH THE HEALING OF WOUNDS
____	____	OVERGROWN SCARS OR KELOIDS
____	____	ALLERGY TO LOCAL ANESTHETICS
____	____	HAVE YOU HAD VAGINAL YEAST INFECTIONS?
____	____	ARE YOU PREGNANT?
____	____	ARE YOU CURRENTLY PLANNING A PREGNANCY?

PLEASE INFORM THE DOCTOR AT ANY TIME IF YOU PLAN TO OR BECOME PREGNANT DURING YOUR TREATMENT PERIOD.

HAVE YOU OR ANY MEMBERS OF YOUR FAMILY (SPECIFY WHO) HAD:

YES	NO		
____	____	ASTHMA	
____	____	HAYFEVER	
____	____	ECZEMA	
____	____	HIVES	
____	____	DIABETES	
____	____	PSORIASIS	
____	____	SKIN CANCER	WHO? _____
____	____	GLAUCOMA	
____	____	OTHER SKIN CONDITIONS (SPECIFY)	

SOCIAL HISTORY:

DO YOU DRINK ALCOHOL? YES NO IF YES, _____ DRINKS PER DAY

DO YOU USE RECREATIONAL DRUGS? YES NO IF YES, WHAT? _____
HOW MUCH? _____

DO YOU SMOKE? YES NO IFYES, HOW MUCH? _____

ANY CONDITIONS NOT LISTED ABOVE:

_____

_____

HAVE YOU EVER HAD:

YES NO

____ ____ HAVE YOU PREVIOUSLY HAD A SKIN PROBLEM OR BEEN UNDER THE CARE OF A DERMATOLOGIST? IF YES, PLEASE DESCRIBE:

_____

____ ____ DO YOU TAKE ANY MEDICINES, DRUGS, OVER-THE-COUNTER PREPARATIONS, VITAMINS OR HERBAL REMEDIES? IF YES, PLEASE LIST:

_____

_____

____ ____ ARE YOU ALLERGIC TO ANY MEDICINES, DRUGS, LATEX, OVER-THE-COUNTER PREPARATIONS OR HERBAL REMEDIES? IF YES, PLEASE LIST

_____

_____

PRIOR HOSPITALIZATIONS AND SURGERY (PLEASE GIVE APROXIMATE DATES)

_____

_____

THE DERMATOLOGICAL EXAMINATION WHICH YOU ARE ABOUT TO RECEIVE IS NOT A COMPLETE PHYSICAL EXAMINATION. IT IS SUGGESTED THAT YOU HAVE A COMPLETE PHYSICAL EXAMINATION PERIODICALLY BY YOUR FAMILY PHYSICIAN OR INTERNIST.

I certify that I have read and filled out the patient registration and medical history form fully and correctly to the best of my knowledge, and that the information that I have supplied is complete and correct. I understand that withholding medical information could lead to complications or problems that may have been prevented if that information were known prior to my care and treatment. I acknowledge that I read information regarding the provider of care in this organization, DNR (Do No Resuscitate), Patient's Bill of Rights and Responsibilities, HIPAA regulations, and information regarding the grievance process.

SIGNATURE: _____ DATE: _____

PLEASE ADD ANY ADDITIONAL INFORMATION WHICH YOU FEEL MAY ASSIST THE DOCTOR IN YOUR CARE:

_____

_____

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New York, NY 10021

PATIENT INFORMATION FORM

THE PRACTICE FINANCIAL POLICY WILL BE GIVEN TO PATIENTS AT THE TIME OF REGISTRATION
ALL PATIENTS MUST SIGN THIS FORM.

OUR PRACTICE FINANCIAL POLICY

Dr. Diane Madfes and her staff are dedicated to providing you with the best possible care and service. To assist you, we have the following financial policies. If you have any questions, please feel free to discuss them with our staff.

PAYMENT IS EXPECTED AT THE TIME OF TREATMENT.
WE WILL PROVIDE YOU WITH A FORM TO PRESENT TO YOUR INSURANCE CARRIER (IF APPLICABLE).
WE ACCEPT CASH, PERSONAL CHECKS, AND CREDIT CARDS
(AMERICAN EXPRESS, MASTERCARD, AND VISA)

MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

PATHOLOGY AND LABORATORY FEES

Pathology and laboratory fees are separate from our fees and will be billed directly to you. You will receive a separate bill from the lab company.

I have read, understand, and agree to the financial policies of this office. I am fully responsible for all professional fees and services rendered.

Signature:

_____

Parent/Guardian
(if minor)

_____

Today's Date: _____