MADFES AESTHETIC
WE ARE HERE FOR YOUR HEALTH AND BEAUTY MEDICAL CENTER
1 E 69th St | New York, NY 10021 | (212) 249-8118

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

SECTION I: PATIENT INFORMATION

TODAY'S DATE ___ ___ / ___ ___ / ___ ___ ___ ___

PATIENT NAME _____
(Last) (First) (Middle)

DATE OF BIRTH: ___ ___ / ___ ___ / ___ ___ ___ ___

AGE _____

SOCIAL SECURITY NUMBER ___ ___ ___-___ ___-___ ___ ___ ___

SEX: M F

MARITAL STATUS: Single Married Divorced Widow

REFERRED BY: _____

HOME ADDRESS: _____ APT # _____

_____
(City) (State) (Zip Code)

HOME PHONE: (___ ___ ___) ___ ___ ___-___ ___ ___ ___ This is my preferred contact number

CELL PHONE: (___ ___ ___) ___ ___ ___-___ ___ ___ ___ This is my preferred contact number

WORK PHONE: (___ ___ ___) ___ ___ ___-___ ___ ___ ___ This is my preferred contact number

EMAIL: _____

OCCUPATION: _____

EMPLOYER NAME: _____

WORK ADDRESS: _____

PRIMARY CARE PHYSICIAN: _____

PHONE NUMBER: (___ ___ ___) ___ ___ ___-___ ___ ___ ___

ADDRESS:_____

PHARMACY NAME:_____

PHARMACY PHONE NUMBER: (___ ___ ___) ___ ___ ___-___ ___ ___ ___

EMERGENCY CONTACT: _____

RELATIONSHIP: _____

PHONE NUMBER: (___ ___ ___) ___ ___ ___-___ ___ ___ ___

IS THE PATIENT A MINOR?

IF THE PATIENT IS A MINOR – FINANCIAL INFORMATION

PERSON RESPONSIBLE FOR PAYMENT:

_____

(Last) (First) (Middle)

RELATIONSHIP TO PATIENT _____

SOCIAL SECURITY NUMBER ___ ___ ___-___ ___-___ ___ ___ ___

DATE OF BIRTH ___ ___ / ___ ___ / ___ ___ ___ ___

HOME ADDRESS: _____ APT # _____

_____

(City) (State) (Zip Code)

HOME PHONE: (___ ___ ___) ___ ___ ___-___ ___ ___ ___

WORK PHONE: (___ ___ ___) ___ ___ ___-___ ___ ___ ___

EMPLOYER NAME_____

WORK ADDRESS_____

CONSENT FOR PHOTOGRAPHY:

I hereby give my permission to my physician or any assistant that she may designate to take photographs for diagnostic purposes and to enhance 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) _____ DATE ___ ___ / ___ ___ / ___ ___

Signature _____

SECTION II: MEDICAL HISTORY

MEDICAL HISTORY: (CHECK ALL THAT APPLY) PLEASE EXPLAIN WHERE APPLICABLE

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	_____
_____	_____	ENDOCRINE DISORDER	_____
_____	_____	URINARY OR BLADDER PROBLEM OR INFECTION	_____
_____	_____	HEPATITIS A, B, OR C	_____
_____	_____	HIV	_____
_____	_____	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	_____
_____	_____	ARE YOU PREGNANT?	_____
_____	_____	ARE YOU CURRENTLY PLANNING A PREGNANCY?	_____

PLEASE LIST ANY MEDICAL CONDITIONS NOT LISTED ABOVE:

HAVE YOU PREVIOUSLY HAD A SKIN PROBLEM OR BEEN UNDER THE CARE OF A DERMATOLOGIST?

NO YES, PLEASE DESCRIBE: _____

DO YOU TAKE ANY MEDICINES, DRUGS, OVER-THE-COUNTER PREPARATIONS, VITAMINS OR HERBAL REMEDIES?

NO YES, PLEASE LIST: _____

ARE YOU ALLERGIC TO ANY MEDICINES, DRUGS, LATEX, OVER-THE-COUNTER PREPARATIONS OR HERBAL REMEDIES?

NO YES, PLEASE LIST: _____

PRIOR HOSPITALIZATIONS AND SURGERY (APROXIMATE DATES)

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

YES	NO	
_____	_____	AUTO-IMMUNE DISEASE (please specify) _____
_____	_____	MELANOMA (please specify) _____
_____	_____	ANY CANCER (please specify) _____

PLEASE INFORM THE DOCTOR AT ANY TIME IF YOU PLAN TO OR BECOME PREGNANT.

SECTION III: SOCIAL HISTORY

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

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

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

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 can obtain and will read information regarding the providers of care in this organization, **DNR (Do Not Resuscitate),** Patient's Bill of Rights and Responsibilities, HIPAA regulations, and information regarding the grievance process.

Signature: _____ DATE ___ ___ / ___ ___ / ___ ___

SECTION IV: OUR PRACTICE FINANCIAL POLICY

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

We 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.

CANCELLATION POLICY
Please note that appointments cancelled within 24 hours of the appointment are subject to a $50 fee."

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

Parent/Guardian (print) _____ DATE ___ ___ / ___ ___ / ___ ___

Signature _____

SECTION V: PATIENT CONSENT FORM -- USE AND DISCLOSURE OF HEALTH INFORMATION PROTECTED UNDER HIPAA

Pursuant to the information contained in the Notice of Privacy Practices, I give permission for the use and disclosure of Protected Health Information (PHI) in order to carry out Treatment, Payment, and Healthcare Operations (TPO).

I am aware that I have the right to review the Notice of Privacy Practices prior to signing this consent. Should the Notice of Privacy Practices be revised, I am aware that I may obtain a copy of the revised form by contacting the Medical Director of this facility.

I give my consent for this organization to contact me by calling my home or other designated location in order to leave a message (mechanically or with another person) or to speak to me directly regarding any matter which will help with the conduct of Treatment, Payment, and Healthcare Operations.

Further, I give my consent for the use of mail or e-mail to designated locations, including my home, to assist the organization in carrying out the described activities of Treatment, Payment, and Healthcare Operations.

I hereby consent to the use and disclosure of my PHI for the purpose of Treatment, Payment, and Healthcare Operations (TPO). This consent is good until revoked in writing, except to the extent those disclosures have been made in reliance upon my prior consent.

Services are provided without regard to sex, race, color, religion, national origin, or disability.

Patient name (print) _____ DATE ___ ___ / ___ ___ / ___ ___

Patient Signature _____

If applicable, Legal Guardian Name: _____

Legal Guardian Signature: _____

SECTION VI: LEARNING ASSESSMENT

During your visit with our organization you will be presented with information that may be new to you.

To aid in providing the best care possible please answer the following questions.

How do you like to learn new things? Please check all that apply:

Brochures Reading
Hands On/Demonstration Discussion

Comments	Yes	No	Factors that can affect learning:
Do you speak English in your home?			If no what language do you speak? Name of interpreter:
Can you read English?			
Can you write English?			
Do you hear well?			If no, do you utilize a hearing device? Yes No
Do you see well?			If no, do you utilize glasses or contacts? Yes No
Do you have any cultural or religious practice/beliefs that may affect your care or treatment?			If Yes, explain:

SECTION VII: UNIVERSAL MEDICATION FORM

Name:	**Address:**_____
Allergies:	**Phone Number:**
Email:	**Birth Date:**

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: 1) Prescription and over-the-counter medications (examples: aspirin, antacids); herbals (examples: ginseng, gingko); and vitamins. Include medications taken as needed (example: nitroglycerin). Please also include if you received any injections recently, i.e. steroids. **2)** CROSS OFF any medications you no longer take. **3)** Keep this card in chart at all times. Show this card to every doctor visit on every visit, every visit to an emergency room and on admission to any hospital. **4)** NEVER take drugs prescribed for someone else.

									OFFICE USE ONLY		
DATE PRESCRIBED	**MEDICATION / DOSE**	**DIRECTIONS: (How many times a day do you take this and when.)**	**Medication held due to procedure**		**DATE STOPPED**	Notes: Reason for taking / **Doctor Name**	**Name of Medication in Office**	**Contra-indicated?**		
			Y	N				Y	N	
			Y	N				Y	N	
			Y	N				Y	N	
			Y	N				Y	N	
			Y	N				Y	N	
			Y	N				Y	N	
			Y	N				Y	N	
			Y	N				Y	N	
			Y	N				Y	N	
			Y	N				Y	N	
			Y	N				Y	N	
			Y	N				Y	N	

_____ ____ / ____ / ____

Patient Signature if applicable Date

_____ ____ / ____ / ____

Responsible Adult Signature Date

_____ ____ / ____ / ____

Signature of representative of organization accepting the patient Date

SECTION VIII: DISCLOSURE INFORMATION

Welcome to the practice, which is owned by Diane C. Madfes.

Your Surgeon/Physician: Dr. Diane C. Madfes is board certified by the American Board of Dermatology and is licensed in the State of New York, Connecticut and Florida. She has been in practice since 1996 and attended Brandeis University and Albert Einstein School of Medicine. She completed her internship in internal medicine at Yale University and her dermatology residency at Albert Einstein School of Medicine. You may request her C.V. which we keep on file. Her training is extensive in the field of dermatology surgery.

Your Surgeon/Physician: Dr. Esther L. Williams is board certified by the American Board of Dermatology and is licensed in the State of New York. She has been in practice since 2014 and attended Columbia University and Albert Einstein School of Medicine. She completed her internship in internal medicine at Staten Island University Hospital and her dermatology residency at Downstate Medical Center. You may request her C.V. which we keep on file. Her training is extensive in the field of dermatology surgery and skin cancer.

The Team: Our team is made up of competent individuals that will assist in providing safe patient care. All our medical assistants are all certified and play an important role in your care.

Should you have a problem: Please be advised that if you have a grievance or concern the following mechanism exists: Ask for the grievance form from the receptionist. Or you may call the accrediting organization that oversees our compliance with standards of care: The Joint Commission on Accreditation of Healthcare Organizations at (800) 994- 6610 or emailing complaint@jointcommission.org.

Make a suggestion: If you have a suggestion, please place this in writing and hand it to the receptionist or mail it.
Play a part in your care: We encourage all patients to be actively involved, so please speak up and ask questions.
DNR Policy: Please be advised that this organization **does not recognize DO NOT RESUSCITATE** orders or Living Wills.
If you have any questions, please see the receptionist.

Signature: _____ Date:___ ___ / ___ ___ / ___ ___

Infection Control: We provide various in-services to our staff on Infection Prevention and Control issues annually. We monitor our organization for infections. This practice educates staff upon hire and annually in hand hygiene and we follow CDC guidelines for hand hygiene. We encourage staff to stay home when sick. We provide tissues and garbage cans throughout the facility and encourage everyone to cover mouths when coughing/ sneezing and wash their hands. Should you have a procedure in this organization, we want you to know that we value patient safety. Therefor you may hear us performing certain tasks or asking certain questions that may surprise you. Even though we may know you, we will ask you identifying information such as your date of birth or your address besides asking you to tell us your name. We take a pause or "time out" before we start your procedure. Only the physician performing your procedure will mark your surgical site. This organization adheres to strict infection control measures before, during, and after your procedure including but not limited to: procedural technique, environment of care, care of equipment and instruments, and education of all staff in the most up to date infection control measures.

JOINT COMMISSION ONLY: If anyone has concerns about patient care/ safety in the organization that we have not addressed, you're encouraged to contact the organization's management. If you feel the concerns were not resolved through the organization, you are encouraged to contact the Joint Commission by calling 800-994- 6610 or emailing complaint@jointcommission.org.

Signature: _____ Date:___ ___ / ___ ___ / ___ ___