

CATSKILL DERMATOLOGY, PC

**110 Bridgeville Road
Monticello, NY 12701
(845) 794-3030**

**1997 Route 17M
Goshen, NY 10924
(845) 294-6123**

PATIENT INFORMATION

Patient's Name _____ Date of Birth _____ Sex _____
Social Security No. _____ Marital Status _____

PERMANENT ADDRESS:

LOCAL / SEASONAL ADDRESS: (If applicable)

Street / PO Box _____ Street / PO Box _____
City _____ City _____
State _____ Zip Code _____ State _____ Zip Code _____

Home Phone _____ Local Phone _____

Cell Phone _____ Employer Name & Phone # _____

IS THE PATIENT THE POLICY HOLDER ON THE INSURANCE? YES NO

PLEASE COMPLETE SECTION BELOW (Circle those that apply)

Policy Holder / Parent / Spouse _____ Date of Birth _____ SSN _____

Relationship to patient _____ Street / PO Box _____

Home Phone _____ Work Phone _____ City _____ State _____ Zip _____

PRIMARY PHYSICIAN: Please Note: If your insurance company requires a referral for specialists, you must present a referral from your Primary Doctor at the time of your visit.

Name: _____ Phone _____

Address _____

INSURANCE INFORMATION: Please Present ALL insurance cards at the front desk at the time of your visit.

Primary Insurance _____ Secondary Insurance _____

Prescription Insurance _____

Catskill Dermatology, PC does not participate with all insurance plans. If Catskill Dermatology, PC does not accept my insurance or I have no insurance coverage, I understand that I am expected to pay in full on the day that professional services are rendered, unless other arrangements have been made in advance. If Catskill Dermatology, PC does accept my insurance, I understand that I am responsible for any amount not covered by my insurance, including deductibles and co-payments.

I hereby authorize treatment of my/my dependant(s) medical condition by Catskill Dermatology, PC.

I hereby authorize Catskill Dermatology, PC to furnish information to my insurance plan(s) concerning my illness and treatment, and assign to the physician all payments for medical services rendered to myself and my dependants. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Signed _____ Dated _____

PATIENT'S NAME: _____

Are you allergic to any medications? (please list) _____

Are you currently taking any medications, including over the counter medications? (please list)

Have you ever been treated for any of the following? (please circle)

Heart disease or pacemaker	yes	no	Emotional / Physical Problems	yes	no
High blood pressure	yes	no	Venereal Disease	yes	no

Have you or any blood relative had any of the following: (please circle and list family member if other than yourself)

Asthma	yes	no	_____	Diabetes	yes	no	_____
Hay Fever	yes	no	_____	Psoriasis	yes	no	_____
Hives	yes	no	_____	Skin Cancer	yes	no	_____
Eczema	yes	no	_____	Melanoma	yes	no	_____

In the last 6 months have you had an accident or operation? Yes No (If yes, please list)

Have you ever been treated for a skin disorder before? Yes No (If yes, please list)

Have you ever had a treatment for the skin called GRENZ RAY treatments? Yes No Don't know

I use sunscreen: always sometimes never What moisturizer do you use? _____

I smoke: always sometimes never What soap do you use? _____

I drink alcohol always sometimes never Do you take birth control pills? Yes No N/A

Are you pregnant or planning a pregnancy? Yes No N/A

In order to ensure your privacy Catskill Dermatology, PC will only discuss your medical records with you, unless written consent is granted to do otherwise. If you wish to permit other person (s) i.e.; husband, wife, parent, child, doctor, etc. to discuss your medical condition with us or to have access to your medical records, those person (s) must be listed below.

NOTE: This consent will remain in effect until changed in writing by the patient or guardian.

1. _____
2. _____
3. _____
4. _____

To the best of my knowledge, the medical information provided is correct.

Signature _____ Date _____