If not using our patient portal, return completed forms:

-By fax (212) 375-4018
-By email to officemanager@cybelefishmanmd.com
-By mail to address below

Cybele Fishman, M.D. , PLLC
Integrative Dermatology
111 Broadway, Suite 1302
New York, NY 10006

PERSONAL INFORMATION

Date: _____

Name: _____ Age: _____ Date of Birth: ____/____/_____

Gender: M ____F____ Patient's Social Security Number: _____

Parent/Guardian Name: (for minor patients) _____

Emergency Contact Name: _____ Phone: _____

Marital Status: Married ____ Single ____ Widowed ____ Divorced ____Domestic Partnered ____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Email Address: _____ Cell Phone: _____

Where would you prefer to be contacted with office matters including test results (circle one)?

Email Cell Home Work / May we leave personal health information on the voicemail/email? Y N

May we send you practice updates and information via email? (not more than every three months) Y N

Occupation: _____ Primary Care Physician: _____

Who referred you to Dr. Fishman (i.e. PCP, other physician, friend/colleague, internet search such as zoc doc,

healthgrades, yelp etc.)? Please list: _____

Primary Insurance Carrier: _____ ID#: _____ Group #: _____

Secondary Insurance Carrier: _____ ID#: _____ Group #: _____
(if applicable)

Pharmacy where prescriptions are filled: _____

_____
(name, address, phone #)

1. What is the main purpose of your visit today? _____

2. Please list current prescription medications you are taking _____

_____

3. Please list current herbs, vitamins and supplements you are taking _____

_____

4. Do you see any of these practitioners regularly? (circle which apply, if any)

Acupuncturist Chiropractor Nutritionist Massage Therapist Naturopath

Other – please specify_____

5. Food allergies? Y N / If yes, to what? _____

6. Medication allergies? Y N / If yes to what? _____

Please describe the reaction when taken _____

7. Have you previously had a skin condition or been under the care of a dermatologist? Y N

(If yes, please describe) _____

_____

8. Have you ever been given radiation therapy (x-ray or Grenz treatments) for your skin? Y N

(If yes, please explain) _____

9. Prior hospitalizations and surgeries (please give approximate dates and reasons) _____

_____

10. For female patients only:
    (a) Are you pregnant? Y N
    (b) Are you currently planning a pregnancy Y N

    Please inform the doctor at any time you plan to become pregnant during your treatment

11. <u>HAVE YOU EVER HAD?</u>

Excessive bleeding when cut	Y	N
Difficulty with healing of wounds	Y	N
Overgrown scars or keloids	Y	N
Allergy to local anesthetics	Y	N

12. HAVE YOU EVER HAD OR BEEN TREATED FOR THE FOLLOWING?

Duodenal or peptic ulcer	Y	N
Intestinal , stomach disease or colitis	Y	N
Liver or gallbladder disease	y	N
Lung disease (tuberculosis, asthma, pneumonia	Y	N
Heart disease (murmur, rheumatic fever, pacemaker)	Y	N
High Blood pressure	Y	N
Stroke	Y	N
Kidney Disease	Y	N
Urinary or bladder problem or infection	Y	N
Sexually transmitted disease	Y	N
Blood or lymph gland disorder	Y	N
Eye disease (glaucoma, cataract, cataract surgery)	Y	N
Arthritis, joint problem or bone disease	Y	N
Cancer/Leukemia	Y	N
Frequent infection (skin or other)	Y	N
Neurological disorder	Y	N
Emotional or psychiatric disorder	Y	N
Are you HIV positive or have reason to believe you may be	Y	N
Do you have Hepatitis or have reason to believe you may	Y	N
If yes, Hepatitis A, B, or C (circle one)		

13. HAVE YOU EVER HAD

Asthma	Y	N	
Hives	Y	N	
Eczema	Y	N	
Diabetes	Y	N	
Psoriasis	Y	N	
Melanoma	Y	N	If yes, date: _____
Skin cancer	Y	N	If yes, what type and date: _____
Other skin condition	Y	N	If yes, please describe: _____
Thyroid problems	Y	N	If yes, please describe: _____

Social History

Do you wear sunscreen? Y N If yes, is it every day or only when you expect a lot of sun exposure? (circle one)
Which sunscreen? (brand and SPF) if possible _____
If no, please explain why not _____
Have you ever used a tanning bed? Y N If yes, _____times per week for _____ years.
Have you had at least one blistering sunburn? Y N
Have you ever smoked cigarettes? Y N If yes, how many cigarettes or packs per day? _____ for _____ years.
Are you still a smoker? Y N If no, when did you quit? _____
Do you drink alcohol? Y N If yes, what and how many drinks a week? _____
Do you drink caffeinated beverages? Y N
If yes, what and how many cups/cans, etc. a day? _____
Do you use recreational drugs? Y N if yes, which? _____
Have you had previous drug/ alcohol problems? Y N
If yes, please explain _____
On a scale of 1-5, 5 being the highest, please rate your stress level _____
Do you manage stress well? Y N
What do you do to manage stress? _____
D o you exercise regularly? Y N If yes, what do you do? _____
Do you enjoy your job? Y N
Do you allow time to unwind/relax? Y N
Do you sleep soundly? Y N if no, why not? _____
On a scale of 1-5, 5 being the most healthy, how healthy is your diet? _____
Are you (please circle either that pertain to you) vegetarian? vegan?

Family History

Has anyone in your family had any of these conditions? You may circle more than one.

Mother - asthma allergies hay fever hives diabetes thyroid problems
psoriasis skin cancer if so, what type _____
melanoma

Father - asthma allergies hay fever hives diabetes thyroid problems
psoriasis skin cancer if so, what type _____
melanoma

Siblings - asthma allergies hay fever hives diabetes thyroid problems
psoriasis skin cancer if so, what type _____
melanoma

Grandparent - asthma allergies hay fever hives diabetes thyroid problems
psoriasis other skin cancer if so, what type _____
melanoma

Are you interested in learning more about the cosmetic treatments we offer? (please circle):

Botox

Fillers (Restylane, Juvederm, Radiesse, Sculptra)

Laser for broken blood vessels

Laser for sun spots

Injections for leg veins

Chemical peels

I hereby authorize Dr. Fishman to examine and treat me as necessary.

Patient name: _____ Patient signature: _____

Date: _____

Cybele Fishman, M.D., PLLC
Integrative Dermatology

Client/Patient Confidentiality

I hereby give my consent for Cybele Fishman, M.D. – Integrative Dermatology to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).
(The Notice of Privacy Practices provided by Cybele Fishman, M.D. – Integrative Dermatology describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.
Cybele Fishman, M.D. – Integrative Dermatology reserves the right to revise its Notice of Privacy Practices at any time.
A revised Notice of Privacy Practices may be obtained by forwarding a written request to Candice Brown/ Cybele Fishman,M.D., PLLC , 111 Broadway, Suite 1302 New York, NY 10006

I give my consent for Dr. Fishman to view and maintain a copy of my Sure Scripts prescription history as part of my clinical medical record. I understand that this information will remain confidential and will not be transferred to outside entities without my written consent.

Assignment and Release: I hereby authorize Cybele Fishman, MD, PLLC to submit claims to my insurer for services rendered by Dr. Fishman and her associates. I hereby assign my insurance benefits to be paid directly to the physician; or if my current policy prohibits direct payment to the doctor, I instruct and direct my insurance company to make the check out to me and the rendering physician. I also authorize the physician to deposit checks received on the patient's account when made out to the patient. I also authorize the physician to release any information required to process claims or in the course of my exam and treatment. I hereby agree to pay my account as services are provided. If for any reason there is a balance owing on my account, I agree to pay promptly upon receipt of the monthly statement. I authorize my physician to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

By signing below I acknowledge acceptance of the terms of this agreement, receipt of the privacy policies, and authorization to maintain a copy of my prescription history in my clinical record.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Cybele Fishman, M.D. – Integrative Dermatology may decline to provide treatment to me.

_____ _____

Print Patient's Name Signature of Patient or Legal Guardian

_____ _____

Print Name of Legal Guardian, if applicable Date

FINANCIAL AND FEEDBACK POLICIES

Cybele Fishman, M.D., PLLC
Integrative Dermatology

111 Broadway, Suite 1302
New York, NY 10006

Patient Name: _____ **Date of Birth:** ____/____/_____

BASIC POLICY Payment for service is due in full at the time the service is provided in our office.

FOR PATIENTS WITH INSURANCE We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid, or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

MEDICARE PATIENTS We will bill Medicare for you. We will also bill secondary insurance carriers for you. All copayments or deductibles are due and payable at the time the service is provided.

MEDICAID PATIENTS We do not accept Medicaid. If you have supplemental coverage through Medicaid, you will be responsible for fees not covered by your primary care insurance.

REFERRALS You are responsible for determining whether a referral is required for your office visit. If you fail to obtain a required referral all professional fees are due and payable in full from you.

NON –COVERED SERVICES Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial, unless an agreement with the practice has been established in advance.

MISSED APPOINTMENTS In fairness to other patients and the doctor, we request 24 hours' notice to cancel appointments. We REQUIRE 24 hours' notice to cancel any appointment booked for 30 minutes or longer. Failure to do so will result in a $50.00 fee. Multiple occurrences can result in dismissal from the practice.

FEEDBACK Billing concerns should be directed toward our billing department and they will be promptly addressed. Any other concerns or grievances you may have should be addressed by speaking with our office manager, or sending us a letter via email, regular mail or fax. By signing below you agree to use the above mentioned mechanisms to express your feedback and that you will not publish your negative feedback and/or grievances on the internet. In the event that you do publish comments about or ratings of the practice that we determine to be damaging in any way, you agree to remove the comments and/or rating within 48 hours.

I have read, understood, and agreed to the above financial policy for payment of professional fees and feedback policy.

The patient is ultimately responsible for all professional fees and for any legal fees incurred by the practice as a result of having to enforce these policies.

Signature: _____ Date: _____