

500 Grand Ave., Suite 201, Englewood, NJ 07631 (201)886-9000 Fax: (201)227-1789

41-61 Kissena Blvd., Suite 5A, Flushing, NY 11355 (718)886-9000 Fax: (718)961-0666

220 East 161st Street, Bronx, NY 10451 (718)292-9197 Fax: (718) 292-4429

40-12 80th St ,Elmhurst NY 11372

**名字 :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Name Last (姓) First (名) M.I.

**地址** : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt. #(公寓號碼): \_\_\_\_\_\_\_\_\_

Street Address (街道地址)

City (城市): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State(州): \_\_\_\_\_\_\_ (郵政編碼)Zip: \_\_\_\_\_\_\_\_

**出生日期:** \_\_\_\_月\_\_\_\_ **日** \_\_\_\_\_\_**年** **工卡號碼** : \_\_\_\_\_\_\_ – \_\_\_\_\_ – \_\_\_\_\_\_\_\_

Date of Birth : MM DD YYYY

**婚姻狀况:** □**單身** □ **已婚** □ **其他 性别:** □ **男** □ **女**

Marital Status: Single Married Other Sex: Male Female

**電話號碼 :** ( \_\_\_\_ ) \_\_\_\_\_\_ – \_\_\_\_\_\_\_\_\_ **手機號碼:** ( \_\_\_\_ ) \_\_\_\_\_\_ – \_\_\_\_\_\_\_\_\_

Home Phone Cellular Phone

**緊急聯繫名字:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**緊急聯繫電話號碼:** ( \_\_\_\_\_ ) \_\_\_\_\_ – \_\_\_\_\_\_\_

Emergency Contact Emergency Phone

**轉診醫生:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**電話:** ( \_\_\_\_\_\_ ) \_\_\_\_\_ – \_\_\_\_\_\_\_\_\_

Referring Doctor Phone

**電郵地址**(Email Address)**:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Language: □ English □ Español □ 한국어 □ 国语 □ 廣東話 □ 日本語 □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**药房信息**

**药房名字：\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_药房电话(\_\_\_\_\_\_)\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_**

您在提交表格给前台时，请把您的所有保险卡提供给我们。

**主要保险Primary Insurance 你的保险需要专疹单看专科吗?** Does your insurance require a referral to see the specialist?  **□ Yes (是) □ No(不是)**

**保單持有人:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Name Last (姓) First (名) M.I.

**持有人出生日期:** \_\_\_\_\_\_ **月** \_\_\_\_\_\_ **日** \_\_\_\_\_\_ **年** **與病人關係:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s DOB MM DD YY Relationship to Patient

**SIGNED: \_\_X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_**



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**Patient Privacy Directive**

In our efforts to comply with the Health insurance Portability and Account Activity (HIPAA), we need to be certain that we guard your privacy according to your wishes. Please provider names and phone number of assigned person(s) we can discuss the matters with.

1. Leave message regarding appointments, treatments and/or test results.
2. Discuss your appointments and billing issues.

Authorized Individual (Print) Phone Number

**By signing this form** I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **AUTHORIZE the following**:

(Patient name/Guardian)

1. For Metro Dermatology to submit all claims on my behalf. I also authorize assignment of benefits directly to this office and release of any records requested by my insurance carrier(s)
2. I ALSO ACKNOWLEDGE THAT IF PAYMENT IS NOT RECEIVED THAT I WILL BE HELD RESPONSIBLE FOR THE ENTIRE BALANCE OF THE BILL. I AGREE TO BE RESPONSIBLE FOR ANY COLLECTION AND COURT COSTS SHOULD MY ACCOUNT BE TURNED OVER TO AN ATTORNEY OR COLLECTION AGENCY. I AGREE TO PAY $35.00 FOR ANY RETURNED CHECK.
3. I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian).

I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals. By consenting to these medical photographs I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact the practice.

1. I acknowledge that I received a copy of the Practice Policy, version 100915.
2. I acknowledge I have seen a copy of the “Notice of Privacy Notices” posted in the office lobby

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| x |  | / / |
| **Print and Signature/Patient or legal representative** |  | Date |