

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

Nombre**:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Name Apellido Primer Segundo Inicial

Direccion\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt.#:\_\_\_\_\_\_\_

Ciudad:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Estado\_\_\_\_\_\_\_Codigo Postal: \_\_\_\_\_\_\_\_\_

Fecha de Nacimiento**:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Seguro Social:\_\_\_\_-\_\_\_\_-\_\_\_\_

Date of Birth MM DD YY Social Security

Estado Civil**:** □Soltero□Casado □OtroSex**:** □Baron□Hembra

Marital Status: Single Married Other Male Female

#De Cellular**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ #Telefono deCasa**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell phone Home phone

Contacto de Emergencia**:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teléfono\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Emergency Phone

Doctor Primario/Referencia: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Teléfono**:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Doctor Phone

Email**:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Idioma Preferido: □English □Español □한국어 □國 語 □廣東語 □日本語 □Other: \_\_\_\_\_\_

**Farmacia Preferida :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Preferred Pharmacy

**#Telefono de la Farmacia: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Pharmacy Phone#

**POR FAVOR PRESENTAR A LA RECEPCIONISTA CON TODAS LAS TARJETAS DE SEGURO MEDICO AL REGRESAR ESTA FORMA.**

PLEASE PRESENT TO THE RECEPTIONIST WITH ALL INSURANCE CARDS WHEN RETURNING THIS FORM.

**Seguro Primario:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Requiere su seguro un refereferido para ver a un especialista??□ SI □ NO**

Does your insurance require a referral to see a specialist? Yes No

Nombre del suscriptor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_

Subscriber’s Name Apellido/Last Name Primer Nombre /First Name Segundo Inicial /M.I

**Fecha de nacimiento del suscriptor: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Relación al paciente: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Subscriber’s DOB: Relationship to Patient**:**

**Firma :X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fecha: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_**

Signature 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 |