Glendale Dermatology
Dr. Ted Brezel
79-59 Myrtle Ave, Glendale, NY 11385

PATIENT INFORMATION

Name: Last_____ **First**_____ **DOB:** ____- ____- _____

Sex: (circle) Male Female Other **Place of Birth:** _____

Language: (circle) English Spanish Other _____

Race: (circle) White American Indian or Alaskan Native Asian

Black or African American Other_____

Ethnicity: (circle) Hispanic Not Hispanic Decline to specify Other

Marital Status: (circle) Married Single Divorced Widowed Other

Who referred you to us? _____

Phone Numbers: Home _____ **Work:** _____

Cell: _____ **Email Address:**_____

Home Address: _____

_____

Primary Care Physician:

Name/ Address: _____**Phone:** _____

Pharmacy Name:_____**Town/Zip:**_____

Pharmacy Phone: _____

The staff and/or Dr. Brezel may need to contact you regarding appointments, test results, return phone calls, etc...

Preferred Contact Method: (circle) Phone Email Patient Portal Other_____

Do we have your permission to:

Leave a message on your answering machine at home/cell? YES NO

Leave a message at your place of employment? YES NO

Discuss your medical condition with any member of your household? YES NO

Emergency Contact: _____ **Relationship to patient:** _____

Phone: _____ **Address:**_____

Notice of HIPAA Privacy Practices

I acknowledge that the Notice of Privacy Practices was available for my review.

Signature _____ **Date** _____

INSURANCE INFORMATION

Primary Insurance : _____ **Self Pay** ☐

Policy Number: _____ **Group Number:** _____

Responsible Party (If other than Patient) _____

Phone Number: _____ **Employer:** _____

RELEASE OF INFORMATION:

I agree that Dr. Brezel may disclose certain health information to a person(s) other than me because such person(s) is involved in my health care or payments related to my health. In that care, Glendale Dermatology will only disclose information that is directly relevant to the person's involvement in my health care or payments related to my health care. I designate the following persons for the limited purposes described above. I understand that I am not required to list anyone, and can change this list at any time in writing.

Name: _____ **DOB:** _____

Name: _____ **DOB:** _____

INSURANCE WAIVER AND COLLECTION FEES

Many insurance companies have started to change an additional co-payment, co-insurance and deductibles for services performed in doctor's offices. In addition, your insurance company considers many of the minor diagnostic test and procedures performed in our office as surgical in nature and as a result subject to different rules over and above the co-payments on your insurance card. We are not always able to determine your full financial responsibility until your insurance company adjudicates the claim. If you are billed an additional amount it is based upon an agreement with your insurance company determining your responsibility. **You are to reimburse us the additional amounts determined by your insurance company and if you do not your balance will be forwarded over to our collection agency. If you balance is forwarded to our collection agency you will in addition be responsible for any collection charges, which is based on a percentage at a maximum of 35% of the debt and all coasts and expenses, including reasonable attorney's fees, we incur in such collection efforts.**

Signature: _____ **Date:** _____

PAST MEDICAL HISTORY: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
BPH
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Thyroid Problems (Hyper or Hypo)
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Pacemaker

NONE

Other _____

PAST SURGICAL HISTORY:

_____
_____
_____
_____
_____

SKIN DISEASE HISTORY: (please circle all that apply)

Psoriasis
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Precancerous Moles
Melanoma
Poison Ivy
Acne
Actinic Keratosis
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Squamous Cell Skin Cancer

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

MEDICATIONS: (Please enter all current medications, including dosage and frequency)

_____
_____
_____
_____

ALLERGIES: (Please enter all allergies)

_____
_____
_____
_____

SOCIAL HISTORY:

Cigarette Smoking:
Never Smoked
Quit: Former Smoker
Smokes Less Than a Pack Daily
Smokes Daily

ALCOHOL INTAKE:

None
Less than one drink per day
1-2 drinks per day
3 or more drinks per day

FAMILY HISTORY: (please circle all that apply)

Melanoma Mother Father Sister Brother Daughter Son
Diabetes Mother Father Sister Brother Daughter Son

PQRS Patient Intake Form

Name: _____ Date: _____

Please answer ALL the following questions so we can comply with Medicare AND Insurance requirements at our practice.

1. Have you received the Influenza vaccine this season? Yes or No
2. Have you received the pneumonia vaccine this season? Yes or No
3. Do you have a history of Melanoma? Yes or No
4. Are you a New Patient (first medical visit)? Yes or N
5. Do you have an Advanced Care Directive/Living Will? Yes or No

   If so, please list your Health Care Proxy: _____

   Who is your primary care physician/ Month and year of last visit

   _____

Only for Medicare patients who **do not** have a secondary supplement.

Acknowledgement of 20% for Medicare patients

I _____ understand that Medicare only covers 80% of my medical and I am responsible for the remaining 20%. I have been explained that Glendale Dermatology does not accept my secondary insurance. Or acknowledge that I do not have any secondary insurance at this time. I understand that I am responsible to pay during the time of the visit.

Signature: _____