

CONFIDENTIAL

PATIENT REGISTRATION

Patient Name _____

Date of Birth _____

Address _____ Apt# _____
_____, _____, _____
City State Zip

Social Security # _____

Sex Male Female Age _____ Minor

Home Phone () _____ Cell () _____

Work () _____ Ext _____

Best Time and Place to Reach You _____

E-mail _____ Employer _____

Occupation _____

Primary Care Physician (Name and Address) _____

Preferred Pharmacy (Name and Phone #) _____

Who Referred you to us? _____

May we thank them? Yes No

Marital Status:

Married Widowed Single Divorced Partnered for _____ years

IN CASE OF EMERGENCY, CONTACT:

Name _____

Relationship to Patient _____

Home Phone () _____ Cell Phone () _____ Work () _____
Ext _____

INSURANCE AND BILLING INFORMATION

Who is responsible for this account? _____

Date of Birth _____

Relationship to Patient _____

Social Security # _____

Insurance Company Name _____

Insurance Company Address _____

_____, _____, _____
Street City State Zip

Identification # _____

Group # / Policy # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Date of Birth _____

Relationship to Patient _____

Social Security # _____

Secondary Insurance Company Name

Insurance Company Address

-----, -----, -----, -----
Street City State Zip

Identification #

Group # / Policy #

Insurance Assignment and Release

I certify that I (and/or my dependent(s)) have insurance coverage with the above named insurance company (ies) and assign directly to Sadick Dermatology (and/or Physicians associated with Sadick Dermatology) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Sadick Dermatology and associated physicians may use my health care information and may disclose such information to the above named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

My visits with Sadick Dermatology will not go through my medical insurance carrier due to the fact that:
I do not have medical insurance coverage, so I accept responsibility to pay in full.
I am visiting this office strictly for cosmetic reasons, not medical, so I accept responsibility to pay in full.
My treating physician does not accept medical insurance, so I accept responsibility to pay in full.

Signature of Beneficiary, Guardian or Personal Representative

Date

Please print name of Beneficiary, Guardian or Personal Representative

Relationship to Beneficiary

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PATIENT MEDICAL HISTORY

ALL QUESTIONS MUST BE ANSWERED. IF SOMETHING DOES NOT APPLY TO YOU, WRITE "NONE" OR "N/A" FOR NOT APPLICABLE.

Patient Name _____

Date of Birth _____

Dermatologic History

1. Reason for visit

How long has this been going on?

What areas are being affected?

How has it been treated?

2. Other Skin Conditions

3. Topical (Skin) medications

4. Other products applied to your skin

Medical History (includes system review)

Do you currently have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
Anemia			Hay Fever/Allergies			Nail Fungus		
Arthritis			Heart Disease/Murmur			Neurological Disorder		
Artificial Joints/Joint Disorder			Hepatitis			Radiation Therapy		
Asthma or Lung Problems			High Blood Pressure			Recent Weight Loss		
Cancer			History of Skin Cancer			Rheumatic Fever		
Cardiac Pacemaker			HIV Infection/AIDS			Seizures		
Cold Sore/Fever Blister			Keloids/Excessive Scar			Stomach/Bowel Problems		
Depression			Kidney/Bladder Problem			Stroke		
Diabetes			Liver Disease or Hepatitis			Thyroid Disease		
Eye Disorder/Glaucoma			Mitral Valve Prolapse			Ultraviolet Light Treatments		

ALL QUESTIONS MUST BE ANSWERED. IF SOMETHING DOES NOT APPLY TO YOU, WRITE "NONE" OR "N/A" FOR NOT APPLICABLE.

Please list all medications you are using
(Including non-prescription, aspirin, birth control, vitamins, herbs and supplements):

Family History of skin cancer/skin diseases: _____

Please list any past surgeries you have had: _____

Do you need antibiotics before Surgical or Dental procedures? YES NO

List any other medical problems/conditions and if these are currently being treated:

	Never	Occ	Freq	Daily
Aspirin Consumption?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ibuprofen, Alieve, Motrin, Advil?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Consumption?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Consumption?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine Consumption?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are you Allergic to any medications (list)?

ALLERGIC TO: -----

Women Only: Are you...

Pregnant or think you may be?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Nursing (breast-feeding)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Taking Oral Contraceptives?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Taking hormone replacements?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Have you ever had excessive bleeding when cut or difficulty with wound healing? YES NO

Signature of patient (or parent, if minor)

Date

Physician's Initial

Date

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Cosmetic Interest Questionnaire

Print Patient's Name _____

Aesthetic issues and areas of concern/interest to you? (please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Frown lines between the brows | <input type="checkbox"/> Facial veins |
| <input type="checkbox"/> Lines around the nose and mouth | <input type="checkbox"/> Excessive Sweating |
| <input type="checkbox"/> Tired looking skin/uneven skin tone | <input type="checkbox"/> Liver spots/Age spots |
| <input type="checkbox"/> Clogged Pores/Large Pores | <input type="checkbox"/> Hair loss (scalp/eye brows/eyelashes) |
| <input type="checkbox"/> Hyperpigmentation or "brown spots" | <input type="checkbox"/> Cellulite |
| <input type="checkbox"/> Sun damage | <input type="checkbox"/> Loose sagging skin |
| <input type="checkbox"/> Scars (acne or other) | <input type="checkbox"/> Tattoo removal |
| <input type="checkbox"/> Leg Veins (varicose or spider) | <input type="checkbox"/> Laser hair removal |
| <input type="checkbox"/> Rosacea, facial red spots | <input type="checkbox"/> Other _____ |

What cosmetic procedures have you had, if any, in the past? (check all that apply)

- Botox Cosmetic / Dysport
- Facial Fillers - Juvederm - Restylane - Perlane - Radiesse - Sculptra -
- Other: _____
- | | |
|--|---|
| <input type="checkbox"/> Chemical peels | <input type="checkbox"/> Microdermabrasion |
| <input type="checkbox"/> Laser facial rejuvenation | <input type="checkbox"/> Laser hair removal |
| <input type="checkbox"/> Other, please specify _____ | |

Were you pleased with the outcome? _____

Are you interested in meeting with one of our professional cosmetic consultant in order to create a Personal Treatment Plan designed to meet your cosmetic needs? (please check one)

- YES No, thanks

CONSENT TO PHOTOGRAPH

(Check one or both)

- I consent to be photographed during the course of my treatment with Sadick Dermatology, and the physician(s) treating me at Sadick Dermatology. I understand that the purpose of such photographs are to track the progress of my treatment(s). I understand that my photographs are part of my medical records and, therefore, are the property of Sadick Dermatology, and the physician(s) treating me at Sadick Dermatology.
- I consent to the use of my photographs, at the discretion of Sadick Dermatology, and the physician(s) treating me at Sadick Dermatology for research, educational and/or scientific purposes. I understand that every attempt will be made to protect my identity and my name will not be disclosed.

Patient's Signature: _____ **Date:** _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO:

Below, please list the name(s) and relationship of any person other than yourself that you authorize Sadick Dermatology, P.C. to release your medical information to.

I **authorize** the following third parties (i.e. **spouse, parent, partner**) to view or receive verbal information regarding my record(s):

Print Name

Relationship

Print Name

Relationship

Patient's Signature

Date

Please check here if you **do not authorize** release of my medical information to any third parties.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

I hereby give my consent for **Sadick Dermatology, P.C.** to use and disclose protected health information (**PHI**) about me to carry out treatment, payment and healthcare operations (**TPO**) (**Sadick Dermatology, P.C.’s Notice of Privacy Practices** provides a more complete description of such uses and disclosures).

I have the right to review the **Notice of Privacy Practices** prior to signing this consent, **Sadick Dermatology, P.C.** 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 **Sadick Dermatology, P.C.’s** privacy Officer at 911 Park Avenue, New York, NY 10021.

With this consent, **Sadick Dermatology, P.C.** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out **TPO**, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, **Sadick Dermatology, P.C.** may mail to my home or other alternative location any items that assist the practice in carrying out **TPO**, such as appointment reminder cards, patient statements and material related to my clinical care as long as it is marked Personal and Confidential.

With this consent, **Sadick Dermatology, P.C.** may e-mail to my home or other alternative location any items that assist the practice in carrying out **TPO**, such as appointment reminders, patient statements and material pertaining to my clinical care. I have the right to request that **Sadick Dermatology, P.C.** restrict how it uses or discloses my **PHI** to carry out my **TPO**.

Sadick Dermatology P.C. is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to **Sadick Dermatology, P.C.’s** use and disclosure of my **PHI** to carry out **TPO**.

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, **Sadick Dermatology, P.C.** may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Date

Print Patient’s Name

D.O.B.

Print Name of Parent or Legal Guardian

ACKNOWLEDGEMENT OF INSURANCE PLAN NON-PARTICIPATION

Patient Name: _____ **D.O.B.** _____

I am fully aware that **Cheryl Karcher, M.D.** is non-participating with any/all medical insurance carriers. I acknowledge and agree that I am fully responsible for any/all costs incurred for my treatment in this office, whether that treatment is of a medical or cosmetic nature. I understand that I am responsible to pay the full cost that Sadick Dermatology has determined to be appropriate for the treatment I receive. I also understand that I am personally responsible for insurance submission of claims should I choose to attempt to obtain reimbursement from my health insurance carrier.

Patient's Signature _____ **Date** _____

IF PATIENT IS A MINOR (UNDER 18 YRS. OF AGE)

Signature of Parent/Legal Guardian (if minor) _____ Date _____

Print Name of Parent/Legal Guardian _____ Relationship _____

IF PATIENT HAS LEGAL REPRESENTATIVE

Patient's Legal Representative (if applicable) _____ Date _____

Print Name of Legal Representative _____ Relationship _____



No Show / Cancellation Policy

If it is necessary for you to cancel your scheduled appointment we ask that you call by 10am one (1) business day in advance. Appointments are in high demand, and your early cancellation will give another patient the opportunity to access timely medical care.

How to Cancel Your Appointment

To cancel a scheduled appointment, please call

Manhattan Office – (212) 772-7242

Great Neck Office – (516) 482-8040

If you do not reach a receptionist, please leave a detailed message with our answering service.

Late Cancellations

Late cancellations will be considered a “no show”.

No Show Policy

A “no-show” is someone who misses an appointment without cancelling it by 10am one (1) working day in advance.

No-Show/Late Cancellation Fees

Any Skincare appointment (Facials etc.) that is broken with late notice will result in a fee of \$50.00.

Any cosmetic procedure appointment that is broken with late notice will result in a fee of \$150.00

If you are unable to keep your scheduled appointment, we want to remind you of the importance of follow up treatments as indicated by your physician.

Doctors reserve the right not to refill prescriptions until any cancellation/no-show fee's are paid in full.

Please note that if you are running late for your scheduled appointment, you should call to alert the office. While we will do our best to accommodate late patients, we may have to reschedule your appointment based on availability.

This Agreement is entered into on (Date) _____.

Patient Signature: _____

Patient's Name (Printed): _____

Last Updated:
