911 Park Avenue
New York, NY 10021
(212) 772-7242

SadickDermatology

833 Northern Blvd.
Great Neck, NY 11021
(516) 482-8040

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 _____________________

1. Reason for visit

____

How long has this been going on?

____

What areas are being affected?

____

How has it been treated?

____

2. Please list any Surgeries/Operations (Medical and Cosmetic) you have had in the past:

1. __________________________ Date of Surgery ___________Complications? _____________
2. __________________________Date of Surgery ____________Complications? ____________
3. __________________________Date of Surgery ___________Complications? _____________

Have you ever been admitted to the hospital? If yes, please explain:

Reason ____ Date ___________________

Reason ____ Date ___________________

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:
____
____

Are you Allergic to any medications (list)?
ALLERGIC TO:______________________________
____

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

	Never	Occ	Freq	Daily
Aspirin Consumption?	☐	☐	☐	☐
Ibuprofen, Alieve, Motrin, Advil?	☐	☐	☐	☐
Alcohol Consumption?	☐	☐	☐	☐
Tobacco Consumption?	☐	☐	☐	☐
Caffeine Consumption?	☐	☐	☐	☐

Women Only: Are you...

Pregnant or think you may be? ☐ YES ☐ NO
Nursing (breast-feeding)? ☐ YES ☐ NO
Taking Oral Contraceptives? ☐ YES ☐ NO
Taking hormone replacements? ☐ YES ☐ NO

_____________________________________ _______________ ____________

Signature of patient (or parent, if minor) Date Physician's Initial Date
Date

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Cosmetic Interest Questionnaire

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

☐ Frown lines between the brows
☐ Lines around the nose and mouth
☐ Tired looking skin/uneven skin tone
☐ Leg Veins (Varicose or Spider)
☐ Face Lift
☐ Neck Lift
☐ Rhinoplasty (Nose Surgery)
☐ Brow Lift / Eye Lid Surgery
☐ Breast Reduction
☐ Breast Enlargement
☐ Breast Lift
☐ Liposuction
☐ Fat Transfer
☐ Abdominoplasty (Tummy Tuck)
☐ Other ________________________________
☐ 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:___________________
☐ Chemical peels
☐ Microdermabrasion
☐ Laser facial rejuvenation
☐ Laser hair removal
☐ 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.

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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

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ACKNOWLEDGEMENT OF INSURANCE PLAN REQUIREMENTS

Patient Name ______________________________________ D.O.B. ________________

I am fully aware that **Misbah Khan, M.D.** only participates with Medicare, GHI, BC/BS, Cigna, Multiplan, United Healthcare, Oxford, Aetna and Healthnet insurance and that she is non-participating with all other medical insurance carriers. If I am not covered by one of the above named insurance carriers, it is my responsibility to know whether or not my medical insurance carrier offers out-of-network benefits for non-participating physicians. I acknowledge and agree that I am fully responsible for any/all co-payment, co-insurance, deductible and/or other claim amount that my insurance company terms "patient responsibility".

I am fully aware that if my health insurance company requires a referral from my primary care physician in order to process and pay my medical claims, it is my responsibility to obtain it prior to being treated by Dr. Khan or any participating physicians at Sadick Dermatology, P.C. I understand that without a valid referral form, my visit is an unauthorized visit and therefore reimbursement will not be provided by my insurance carrier. In the event my referral does not arrive or is dated after the date of receiving services at Sadick Dermatology, I understand that I am fully responsible for payment for the treatment I receive.

I understand that any treatment I receive that is of a cosmetic nature will not be submitted to or covered by my insurance carrier and that I am responsible to pay the full cost that Sadick Dermatology has determined to be appropriate for the treatment I receive.

____ _______________
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 RESPRESENTATIVE

____ _______________
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:
____