Bruce P. Robinson, M.D., F.A.A.D.

Diplomate American Board of Dermatology
121 East 60th Street, Second Floor
New York, New York 10022
www.BruceRobinsonMD.com
(212) 750 - 7121

Date: ______________________ New: _______ Update: _________

Patient's Last Name:______________________ First:______________ MI: _________

Address:______________________ Apt. #: ______ E-Mail: ______________

City:______________________ State: _________ Zip Code: ______________

Home Telephone:______________ Cell:______________ Work: ______________

Date of Birth:______________ Age:________ Social Security #: ______________

Marital Status:__________ Name of Spouse:______________________

Patient's Gender:________ Patient's Occupation: ______________________

Patient's Employer:______________________ Address: ______________________

Person to contact in case of emergency: ______________________

Relationship:______________ Telephone #:______________________

Whom may we thank for referring you? ______________________

Physician Name, Address and Telephone: ______________________

If you have been referred by a physician, a consultation will be performed and a consult letter sent to the referring physician.

Primary Insurance:______________________ Secondary Insurance: ______________

Identification #:______________________ Identification #: ______________________

Name of Insured:______________________ Name of Insured:______________________

Date of Birth:______________________ Date of Birth: ______________________

I hereby assign my insurance benefits to be paid directly to the physician in this office. I am financially responsible for non-covered services. I hereby authorize the release of medical information related to the services received in this office. Patient is responsible for informing our practice of any change in health insurance plans.

I acknowledge that the office of Dr. Robinson has given me (the patient) the contact information for LabCorp, Quest, and AmeriPath.

____
Patient or Guardian Signature

Our office offers the convenience of having a credit card on file. Balances, co-payments, co-insurance, deductibles and cosmetic procedures for yourself as well as dependent's can be charged to your credit card with written authorization. By filling in the information below, you will be giving your consent to bill your c.c. for current and/or future charges. Your signature will therefore represent a pre-authorized order. Our office will always notify you by sending you a paid receipt.

Credit Card: Amex/Visa/MC Card #: ______________________ Security Code:__________
(Circle One)

Expiration Date: ______________

Signature of Credit Card Holder: ______________________

Print Name: ______________________________________

Billing address for this credit card: ______________________________________

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Current everyday smoker? ______ Current some days smoker? ______ Former smoker? _________________

Never smoked? ______ Smoker, current status unknown______ Unknown if ever smoked ________________

Start date______ Quit date_______ Cessation counseling offered______ Date offered ___________________

Please list current medications: ____

____

Please list allergies to any oral or topical medications: ____

Primary reason for appointment (list single problem here): _____________________________________

How long have you had this problem? ____

Have you received treatment for this problem?______ If so, please describe:___________________________

Was treatment helpful?______ Problems with treatment: ____

____

How do you currently care for the skin of the involved area? ______________________________________

____

Do you have other skin problems you would like evaluated?____

____

PLEASE NOTE: These problems may require a second appointment. If you have more than one problem treated during this visit, your insurance may refuse payment. There is an increase in skin cancer, including melanoma (mole cancer). The doctor recommends a yearly skin exam to evaluate moles.

If you have not had moles checked by a dermatologist, would you like to have them checked for melanoma?
Yes______ No______

Do you have any of the following? History of Rheumatic Fever: Yes______ No_______

Heart valves or joints replaced: Yes______ No______ Mitral Valve Prolapse: Yes______ No______

Are you take steroids or blood thinner? Yes______ No______

Have your or any blood relatives had melanoma? Yes______ No_____

Are you planning to get pregnant, currently pregnant, or nursing? Yes______ No_____

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Is there anything about your medical history which would be useful or important for the doctor to know?

____

____

In order to ensure we are meeting our patient's cosmetic needs, we ask that you complete the following questionnaire. Please check all that apply.

These areas are a concern or interest to me:

- ☐ Fine lines and wrinkles
- ☐ Brown/Age/Sun spots
- ☐ Red Spots
- ☐ Broken Capillaries
- ☐ Acne Scars
- ☐ Leg Veins
- ☐ Thin Lips
- ☐ Fillers: Juvederm, Radiesse or Restylene
- ☐ Tattoo Removal
- ☐ Blue veins around eyes
- ☐ Sun Damage
- ☐ Anti-aging creams
- ☐ Removal of Pencil Tattoo
- ☐ Wrinkles on forehead
- ☐ Chemical Peels
- ☐ Fraxel Laser
- ☐ Lines around the nose and mouth
- ☐ Tired looking or uneven skin tone
- ☐ Unwanted hair-bikini, underarms, lip, chin
- ☐ Dark circles or puffiness of eyes
- ☐ Surgical Scars
- ☐ Blood vessels around nose
- ☐ Lines around mouth, lips and eyes
- ☐ Excessive Sweating-underarms/palms/forehead/lip
- ☐ Longer Eye Lashes
- ☐ Aging Hands/Veins on Hands
- ☐ Rough textured skin
- ☐ Moisturizing creams
- ☐ Removal of Eyebrow Tattoo
- ☐ Wrinkles adjacent to the eyes (crow's feet)
- ☐ Botox

Thank you for taking the time to allow us to better understand your concerns. Please do not hesitate to discuss your concerns with Dr. Robinson. You can also obtain additional information and before and after pictures by visiting our website www.BruceRobinsonMD.com

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NO-SHOW AND PAYMENT COLLECTION OFFICE POLICY

Dear Valued Patient:

Please be advised that we require no less than 24 hours notice whenever an appointment is cancelled. Patients are billed for NO-SHOW appointments. The current NO-SHOW fee is $50.00.

Insurance companies are not responsible for NO-SHOW bills. In the event that you realize you won't be able to keep an appointment during the weekend, you should leave a message cancelling your appointment with our service. Be sure to note the name of the service operator. Again, 24 hours notice is required for cancellations. If you cancel an appointment with our office staff, you should note her name as well.

All payments and co-payments are due at the time of service to avoid a $5.00 surcharge fee.

We thank you in advance for your cooperation.

This form must be signed before you see your physician.

____________________________________ ____________________
Please Print Name Date

____________________________________ ____________________
Signature Date

____________________________________ ____________________
Witness Date

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Dr. Robinson may use and disclose protected health information about me to carry out treatment and conduct payment and health care operations. Please refer to Dr. Robinson's Notice of Privacy Practices for a more complete description of such uses and disclosures. It is available upon request.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Robinson reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Robinson at 121 East 60 Street, New York, NY 10022.

With my consent, Dr. Robinson may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment and to conduct payment and healthcare operations such as appointment reminders, insurance items, and any call pertaining to my clinical care including laboratory results among others.

With my consent, Dr. Robinson may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminder cards and patient statements. I have the right to request that Dr. Robinson restrict how he uses or discloses my Protected Health Information to carry out treatment, payment and healthcare operations.

However, the practice 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 Dr. Robinson's use and disclosure of my Protected Health Information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior agreement. If I do not sign this consent, Dr. Robinson may decline treatment to me.

____ _____________________
Signature of PATIENT or Legal Guardian Date

____
Print PATIENT Name or Legal Guardian Name

Patient Consent for Photography

I authorize The Dermatology Practice of Bruce P. Robinson M.D., the practice along with its physicians and staff to take photographs of either myself or my minor child (a person for whom I am a legal guardian).

I understand these pictures are necessary to use in the electronical medical records system utilized and will be used for the purpose of documenting either the lesion(s) being biopsied, the surgery being undertaken or for any cosmetic procedure(s). These photos can be shared with other physicians who may be involved in my care and may also be used for promotional materials (such as practice location, on website, brochure, or social media).

Please initial if you **do not** want your photos used on any promotional materials. ____________ Refusal to consent to photograph for the purpose of promotional materials will in no way affect the medical care I receive.

Although my full name will not be used, it may be possible for others to identify me in the pictures. By consenting to these medical photographs, I understand that I will not receive payment from any party.

The person/organization authorized to use/disclose the information will not receive any compensation for doing so.

I understand that I have the right to revoke this authorization, in writing, but I understand that any disclosure and release of my photographic images made prior to the time of such revocation cannot and will not be recalled.

I hereby release and discharge The Dermatology Practice of Bruce P. Robinson M.D., physicians and staff (the practice) office, employees and patients from any claims, demands, agents' actions, or causes of action against The Dermatology Practice of Bruce P. Robinson M.D. for use of these images.

Federal Law guarantees a patient's right to maintain privacy of medical information. Images, both still and motion taken before, during, and after medical procedures are considered part of patient's medical information.

I have read and understood the forgoing, and I have had the opportunity to ask any questions I have about this authorization to use my photographic images. I also understand that my treatment will not be conditioned upon my agreement to sign this authorization form.

______________________________________ Date _________________________
Signature of Patient (or parent/legal guardian)

______________________________________ _____________________________
Printed Name of Patient Witness (medical staff)
(or parent/legal guardian)

Bruce P. Robinson, MD
Patient COVID-19 Questionnaire

Name:

Date:

1. **Have you had any COVID-19 symptoms in the past 14 days? (Respiratory illness, new shortness of breath or difficulty breathing, fever, chills. Muscle pain, new cough or runny nose, new sore throat, headaches or new loss of taste or smell, new vomiting or diarrhea)**

Circle one: Yes or No

2. Have you been in contact with anyone who has been ill or tested positive for COVID-19 in the past 14 days?

Circle one: Yes or No

3. Have you traveled outside of NY, NJ, or CT in the past 14 days? If yes, where have you traveled?

Circle one: Yes or No

4. Has anyone in your household traveled outside of NY, NJ, or CT in the past 14 days? If yes, where have you traveled?

Circle one: Yes or No

5. ONLY the patient will be allowed in the office, UNLESS they are a minor, in which case they may be accompanied by ONE parent.

Initial: ________

6. Patients and visitors will be required to wear a face mask/face covering at ALL times while in our building and office.

Initial: ________

Have you had a Covid Vaccine yet?

Moderna/Pfizer: Dose 1 ___ Date: ______

Dose 2 ___ Date: ______

Johnson & Johnson ___ Date: ______