

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 before charging your card

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