NEW PATIENT INFORMATION

Name ______________________________
Street Address ______________________________
City ______________________ State __________ Zip __________
Date of Birth ____/____/______ Marital Status __________ Sex ______ SS# __________
Home Phone ( ) __________ Work Phone ( ) __________ Cell Phone ( ) __________
Employer ______________________________
E-mail Address ______________________________
(May we please have your email address so we can send you information about our services)

Emergency Contact __________________ Relationship to Patient __________
Home Phone ( ) __________ Work Phone ( ) __________ Cell Phone ( ) __________

Who Is Your Medical Doctor Internist/General Practitioner

Name ______________________________
Address ______________________ Phone ( ) __________
City ______________________ State __________ Zip __________
Did he refer you for consultation? Yes ❑ No ❑ Letter to referring Doctor? Yes ❑ No ❑

Referred By: ❑ Physician ❑ Family/Friend ❑ Advertisement ❑ Yellow Pages ❑ Insurance Plan ❑ Website

Policy Holder / Primary Insurance Information

Name __________________ SS# __________ DOB ____/____/______
Name of Insurance Company __________ ID/Policy # __________ Group # __________
Insurance Company Address ______________________________
Relationship to Patient __________________ Employer __________

Secondary Insurance to File

Name __________________ SS# __________ DOB ____/____/______
Name of Insurance Company __________ ID/Policy # __________ Group # __________
Insurance Company Address ______________________________
Relationship to Patient __________________ Employer __________

Do we have your permission to:

Leave a message on your answering machine at home? ❑ YES ❑ NO
Leave a message at your place of employment? ❑ YES ❑ NO
Discuss your medical condition with any member of your household? ❑ YES ❑ NO

If yes, whom: __________________ Relationship __________

I authorize the release of medical information necessary to process this claim and also authorize payment of medical benefits to the physician. I understand that it is my responsibility to present all insurance requirements to the office, i.e., insurance cards and referrals, and if I do not, I will be responsible for payment that day and will be reimbursed if I present such within 24 hours. Your signature below signifies your understanding and willingness to comply with this policy. I have been given an opportunity to review the office HIPPA policies.

Patient Signature ______________________________ Date __________

NEW YORK COSMETIC, SKIN & LASER SURGERY CENTER

CAMERON K. ROKHSAR, M.D., F.A.A.D. F.A.A.C.S

PATIENT MEDICAL HISTORY

Name: ______________________________ Height: __________ Weight: __________ Date: __________

Please check and, if applicable, circle, any of the following conditions you currently have or have had in the past.

______ Skin Cancer (type: ______________________)
______ Other Cancer (type: ______________________)
______ Heart Disease (heart attack, angina, rheumatic fever, heart valve replacement, atrial fibrillation, mitral valve prolapse)
______ High Blood Pressure
______ Pacemaker
______ Stroke or TIA (transient ischemic attack)
______ Blood Clots
______ Immune Deficiency
______ Endocrine Disorder (diabetes, Cushings)
______ Artificial Joints
______ Blood/Lymph Gland Disorder (anemia, leukemia, low Platelets, lymphoma, hemophilia, sickle cell)
______ Taken Accutane (for acne treatment)
______ Neurologic Disorder
______ Frequent Skin Infections
______ Ear Disease (deafness, Meniere's, acoustic neuroma
______ Eye Disease (glaucoma, cataracts, blindness)
______ Duodenal or Peptic Ulcer
______ Intestinal Disease (irritable bowel, ulcerative colitis, Crohn's)
______ Liver or Gall Bladder Disease
______ Lung Disease (tuberculosis, asthma, emphysema, pleurisy)
______ Kidney Disease
______Urinary or Bladder Problem/Infection
______ Arthritis, Joint, Muscle or Bone Disease (lupus, Raynauds, scleroderma)
______ Radiation Treatment ______Chemotherapy
______ Emotional or Psychiatric History

- Have family members had: ____ Melanoma _____Insulin-Treated Diabetes _____Excessive Scarring ____ Cancer (type: ___________)
- Do you: _____Smoke (cigarettes, cigars, pipes) _____ socially drink alcohol (_____drinks/week) _____Use street drugs (type: _________)
- Please circle if you take any of the following on a Regular basis:
  Coumadin Aspirin Vitamin E Garlic Tablets Ginkgo Biloba Ginseng Ginger
- Do you have any allergies to any medications (please circle) YES or NO, if yes please list medications and your reaction to them:
- Please circle if you have ever had an allergy or problem with any of the following and indicate on the line below you reactions:
  Local Anesthetic Epinephrine (Adrenaline) Latex Adhesives/Band-aids Antibiotic Ointment (i.e. – Neosporin, Bacitracin)
- Have you or any family member had problems with anesthesia? NO YES ______________________________
- Have you ever had any problems with sulfites, commonly found in red wines and salad bars? NO YES ________________
- Please list any prior hospitalizations & surgeries: ______________________________________

FOR WOMEN ONLY: Do antibiotics cause you to have yeast vaginitis? ______ Are you pregnant or nursing? ______ Have you missed you last menstrual period? _______ Are you planning a pregnancy? ______ Date of last mammogram? _______

** Please inform us if any of these become true during the course of your treatment at subsequent visits.*

- If a spouse, parent, child, sibling or friend were to ask questions reguarding your care, do you authorize Dr. Cameron Rokhsar to discuss your care? If so, with whom? (Please write names & relationship to you) ______________________________
- Do you allow us to leave medical information, such as laboratory results or answers to medical questions that were asked of us, on your voice mail or answering machine? NO YES

Signature ______________________________________ **Date** ______________

PRIVACY AGREEMENT

Dr. Cameron Rokhsar and The New York Cosmetic Skin & Laser Surgery Center (collectively labeled "*Physician*") agree to provide treatment to the below named patient. The Physician takes pride in being able to extend a greater degree of privacy than is required by law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, physicians are forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Physician believes this is improper and may not be in the patients' best interest. Accordingly, Physician agrees not to provide medical information for the purpose of marketing directly to Patient. Regardless of legal privacy loopholes, Physician will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of "rating sites" in cyberspace, many fail to provide useful information. Let's get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

Nothing in this Agreement prevents a patient from posting commentary about the Physician - his practice, expertise, and/or treatment - on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if Patient prepares such commentary for publication on web pages, blogs, and/or mass correspondence about Physician, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Physician for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary.

This Agreement shall be in force and enforceable for a period of five years from Physician's last date of service to Patient. As a matter of office policy, Physician is requiring all patients in its practice sign the Mutual Agreement so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Physician's patients. Further, this Agreement will survive for a minimum of three years beyond any termination of the Physician-Patient relationship.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

PRINT NAME: SIGNATURE: DATE:

NEW YORK COSMETIC, SKIN
& LASER SURGERY CENTER

CAMERON K. ROKHSAR, M.D., F.A.A.D., F.A.A.C.S.

Cancellation Policy for Appointments

Any time you are unable to keep your appointment, we would appreciate a call in advance from you so that we may cancel your appointment and use the appointment time for another patient. This serves as notice that if you fail to give us a 48-hour notice of cancellation for an appointment, there will be a $75.00 cancellation fee billed to your account that is non-covered by your insurance. You will bear complete financial responsibility for this fee.

I understand Dr. Rokhsar's appointment cancellation policy and understand my responsibility to plan appointments accordingly and notify the office appropriately if I have difficulty fulfilling my scheduled appointments.

____________________ ______________
Patient Signature Date

Credit Card Policy

A valid photo ID is required when paying by credit card.
We apologize for any inconvenience. Thank you.

____________________ ______________
Patient Signature Date