ROBERT L. WARNER, M.D.
JEFFREY S. ROTH, M.D.
580 PARK AVENUE
NEW YORK, NY 10065
(212) 752-3692

PLEASE PRINT

DATE	NAME: MR. MS. LAST	FIRST	MIDDLE INIT

PARENT NAME: (If Patient is a Child)

HOME ADDRESS:

CITY STATE ZIP

BUSINESS NAME & ADDRESS:

CITY STATE ZIP

OCCUPATION:

LOCATION OF YOUR SKIN TROUBLE: DURATION:

SOCIAL SECURITY NUMBER:

TELEPHONE NUMBERS:
HOME:
CELL:
BUS:

EMAIL:

AGE: DATE OF BIRTH:

REFERRED BY:

ALL MEDICATIONS NOW TAKEN: PLEASE INCLUDE MEDICATIONS TAKEN OCCASIONALLY

ALLERGIES

OTHER ILLNESSES:

PERSONAL MEDICAL HISTORY

	Yes	No		Yes	No
Aspirin Therapy			Hives		
Ulcer			Heart Condition		
Diabetes			Pacemaker		
Tuberculosis			History of Skin Cancers`		
High Blood Pressure			History of Melanoma		
Excess Scar Formation			HIV Infection		
Bleeding Problems			Hepatitis B		
Asthma			Hepatitis C		
Hay Fever					

FAMILY MEDICAL HISTORY

	Yes	No	RELATIONSHIP TO PATIENT
Asthma			
Hay Fever			
Eczema			
Skin Cancer			
Melanoma			
Other			

I request that payment of Medicare benefits and/or other commercial insurance company benefits, be made on my behalf to the above physicians.

I also request that payment of Medicare benefits and/or other commercial insurance company benefits, be made on my behalf to the laboratory, if laboratory tests are required.

I authorize the release to my insurance carrier of any medical information needed to determine these benefits or the benefits payable for related services.

Signature

Print Name

IN CASE OF EMERGENCY NOTIFY:

Name:

Address:

Telephone:

Relationship:

PATIENT CONSENT FORM

ROBERT L. WARNER, M.D.
JEFFREY S. ROTH, M.D.
580 PARK AVENUE
NEW YORK, NEW YORK 10021
(212) 752-3692

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____