

**ARIEL OSTAD, MD PC**  
**897 Lexington Avenue, New York, NY 10065 Phone: 212-517-7900**

**PATIENT REGISTRATION INFORMATION**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_  
STREET: \_\_\_\_\_ APT #: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
SEX: (M/F) \_\_\_\_\_ HOME PHONE: \_\_\_\_\_ WORK PHONE \*\*: \_\_\_\_\_  
CELL PHONE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
SOCIAL SECURITY #: \_\_\_\_\_ MARITAL STATUS: \_\_\_ Married \_\_\_ Single \_\_\_ Significant Other  
IN CASE OF EMERGENCY, PLEASE CONTACT: \_\_\_\_\_  
RELATIONSHIP TO YOU: \_\_\_\_\_ PHONE: \_\_\_\_\_  
EMAIL \*\*: \_\_\_\_\_ \*\* May we send you educational information? \_\_\_ YES \_\_\_ NO  
ARE YOU EMPLOYED? \_\_\_ NO \_\_\_ YES: If yes, complete below.  
EMPLOYER NAME: \_\_\_\_\_

**\*\*\* Were You Referred By a Doctor? \_\_\_ No \_\_\_ Yes: If Yes, please give us the contact information of your doctor:**

**REFERRING MD NAME:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**Referred By:** \_\_\_ Website \_\_\_ Family/Friend \_\_\_ OTHER: \_\_\_\_\_

**HEALTH INSURANCE INFORMATION**

**PRIMARY INSURANCE NAME / CLAIMS ADDRESS:** \_\_\_\_\_  
\_\_\_\_\_ PHONE: \_\_\_\_\_

ID#: \_\_\_\_\_ GROUP #: \_\_\_\_\_

**ARE YOU THE POLICYHOLDER?** \_\_\_ YES \_\_\_ NO: **If not, please complete the information below on the policy holder.**

INSURED'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ SEX: (M/F) \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_ EMPLOYER PHONE: \_\_\_\_\_

**SECONDARY INSURANCE-** NAME: \_\_\_\_\_

PHONE: \_\_\_\_\_ ID#: \_\_\_\_\_ GROUP #: \_\_\_\_\_

INSURED'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ SEX: (M/F) \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION:**

I hereby authorize Ariel Ostad, MD, PC, and its associate physicians and para-professionals, to bill the above referenced health insurance companies on my behalf for any/all services performed. I hereby assign all insurance payment benefits directly to this physician group should they accept assignment to my insurance carriers. I understand that any payments that I may receive directly, for services which were billed on my behalf by the physicians, must be turned over to the physician. I understand that I am financially responsible for any/all charges not payable by my insurance carriers. I hereby authorize the release of any information necessary to secure payment of benefits. I affirm that I have been offered a copy of the patient bill of rights and provider information and may ask for a personal copy to take with me.

\_\_\_\_\_  
PATIENT / LEGAL GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

FINANCIAL POLICY

***Please take a few moments to read the following information regarding the office financial policy:***

1. Your insurance may require authorization from your Primary Care Physician (PCP) in order to be examined. It is ***your responsibility*** to obtain the referral/authorization from the primary doctor (PCP) ***in advance*** of your scheduled appointment to allow their office staff to generate an active referral on your behalf. (Some referrals are paper and some are electronic). **Please be aware that if you arrive without a valid referral/authorization, your appointment will have to be rescheduled.**

**THIS IS YOUR INSURANCE COMPANY POLICY...NOT OURS!**

2. You may also require authorization from your PCP for all required follow-up visits. It is your responsibility to call your PCP to inquire if additional referrals are needed, the number of visits allowed, and date of expiration that their office has authorized on your behalf.
3. Please remember that your insurance payments to this office may not be 100%. Oftentimes there is patient responsibility in the form of deductible and / or co-insurance amounts. (Some insurers pay fixed allowances for certain procedures and others pay a percentage of the charges. It is your responsibility to pay any deductible and / or co-insurance amounts and / or any other balances not paid by your insurance carrier such as co-payments.
4. In order to control our billing costs, **any unpaid balance that exceed 90 days or more will be assigned to the attorney for collections.** The patient and / or guarantor will be held responsible for any attorney fees, costs for collections, court costs and interest from the date of service.

I have read the above financial policy and understand my financial responsibilities to the practice.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**Our office Policy:**

It is the responsibility of the patient to provide to the office all NECESSARY REFERRALS from your primary care physician, if required. Treatment will otherwise be provided on a self-pay basis. It is our office policy to maintain a credit card on file. Patients who have an HSA account, deductibles not met, and co-insurances are required to leave a credit card on file in order to ensure proper collection of payment is made. I authorize the unpaid patient due balance to be charged to my major credit card, as listed within 30 days:

Credit Card# \_\_\_\_\_ Exp/Date \_\_\_\_\_

Signature \_\_\_\_\_



## ***Medical History Assessment***

NAME \_\_\_\_\_ DATE \_\_\_\_\_

AGE \_\_\_\_\_ SEX: \_\_\_ Male \_\_\_ Female

Reason For Today's Visit: \_\_\_ Total Body Skin Check \_\_\_ Problem: (Describe) \_\_\_\_\_

**HPI: History of Today's Problem(s):**

LOCATION (skin area(s) involved) \_\_\_\_\_

DURATION (how long has problem been present?) \_\_\_\_\_ Days \_\_\_\_\_ Weeks (s) \_\_\_\_\_ Month (s) \_\_\_\_\_ Year (s)

TIMING (was there any previous treatment?) \_\_\_ No \_\_\_ Yes : When? \_\_\_\_\_

CONTEXT (was a biopsy done?) \_\_\_ No \_\_\_ Yes : If yes, by whom: \_\_\_\_\_

**Check all that apply regarding today's problem:**

**Quality**

*A change in:*

- size
- color
- elevation
- hardness

**Modifying Factors**

*A history of:*

- x-ray treatment
- ultraviolet light treatment
- arsenic exposure
- chronic scar
- immunosuppression

**Associated Symptom**

- bleeding
- tingling/pain
- ulceration
- infection
- itching

**Severity**

- no symptoms
- occasional symptoms
- constant symptoms

Are you ALLERGIC to any medications?  Yes  No If yes, list:

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

List all medications you are currently taking:

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

**Check all that apply regarding your overall health and add any other important information:**

**Skin**

- normal
- keloids
- poor healing
- skin problems

**Hematologic Lymphatic**

- normal
- anemia
- bleeding problem
- enlarged lymph nodes

**Constitutional Symptoms**

- none
- weigh loss
- fever
- other

**Eyes/Ears/Nose/Throat**

- normal
- glaucoma
- hearing aid
- plastic surgery

**Cardiovascular**

- normal
- angina
- artificial heart valve
- pacemaker
- hypertension
- Heart attack:  
When: \_\_\_\_\_

**Respiratory**

- normal
- asthma
- emphysema
- other lung problem

**Gastro-intestinal**

- normal
- stomach ulcer
- colitis
- other GI problem

**Musculoskeletal**

- normal
- arthritis
- artificial joint
- other \_\_\_\_\_

**Neurological**

- normal
- stroke
- seizures

**Psychiatric**

- normal
- depression
- anxiety attacks

**Endocrine**

- normal
- diabetes
- thyroid problem

**Infections**

- none
- hepatitis
- HIV/AIDS
- tuberculosis (T.B.)

**\*\*SEE NEXT PAGE!!**

## ***Medical History Assessment, Page 2***

NAME \_\_\_\_\_ DATE \_\_\_\_\_

PATIENT ACCT # \_\_\_\_\_

Other Important Medical Information: \_\_\_\_\_

**Past Medical History** (check answer)

Previous Skin Cancer?  Yes  No

Major Illnesses or Hospitalizations?  Yes  No If Yes, List \_\_\_\_\_

**Family History (skin cancer):**

melanoma       basal cell or squamous cell       No history

**Social History:** (check answer)

Do you wear glasses?  Yes  No      Dentures?  Yes  No      Contact lenses?  Yes  No

Do you smoke?       No       Yes      If yes, how many packs per day? \_\_\_\_\_

If you are a former smoker when did you stop? \_\_\_\_\_

Do you consume alcohol?  Yes - Socially or Regularly (circle response)       No       Never

Alcohol or drug problems?  Yes  No Addictions?  Yes  No If yes, describe \_\_\_\_\_

May we leave a message on your answering machine?       YES       NO      If Yes: Please Write your BEST contact number:

\_\_\_\_\_ This is my:    \_\_Work    \_\_Cell    \_\_Home

May we leave a message at your place of employment?       YES       NO

**AREAS OF AESTHETIC CONCERN:**

- Fine lines and wrinkles
- Lines around the nose and mouth
- Brown Spots/freckles
- Red Spots
- Sagging skin
- Eyelashes: Fuller, darker, longer
- Skin Hyperpigmentation
- Unwanted Hair
- Dark circles/Puffiness
- Scars, including acne or surgical
- Blue or red leg veins
- Blood vessels around nose or face
- Other: \_\_\_\_\_

\_\_\_\_\_  
**PATIENT SIGNATURE**

\*\*\*\*\*  
(For office use) REVIEWED BY: \_\_\_\_\_ (Staff Person)