Complete Care Dermatology

MIMI BANSAL M.D., F.A.A.D.

PATIENT REGISTRATION **Today's Date _____**

Name _____ SS# _____

Street Address _____ Birth Date: _____ Sex M F

City _____ State _____ Zip_____

Home _____ Work _____ Cell _____

Email Address _____

Spouse's Name _____ Spouse's Phone # _____

Emergency Contact _____ Tel# _____ Relationship _____

Employer Name, Address and Phone Number _____

_____

REFERRING DOCTOR

Referring Doctor _____ Telephone _____

Street Address _____ City _____ State _____ Zip _____

PHARMACY INFORMATION

Name _____

Address _____

City _____ State _____ Zip _____ Telephone _____

INSURANCE INFORMATION

Medicare # (if applicable) _____

Primary Insurance Company _____

ID# _____ Group # _____ Tel# _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGMENT OF BENEFIT

- I hereby authorize Dr. _____ to apply for benefits on my behalf for covered services rendered by him/her or his/her order.
- I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.
- I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

DATE _____ SIGNATURE _____

PREFERENCE FOR COMUNICATION

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that applies):

☐ Home Telephone _____ ☐ Written Communication

- ☐ O.K. To leave Message with detailed information
- ☐ Leave Message with call back number only
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

☐ Cell Number _____ ☐ Work Telephone _____

- ☐ O.K. to leave Message with detailed information
- ☐ Leave message with call back number only

☐ Other (list here any individual we may release medical information to)

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

_____ _____

Print Name Birth Name

_____ _____

Signature Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limits the use or disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Health care entitles must keep records of PHI disclosures. Information provided above, if completes properly, will constitute an adequate record.

Note: Uses and disclosers for treatments may be permitted without prior consent in an emergency.

PRIVACY NOTICE ACKNOWLEDGMENT

Acknowledgment of Receipt

A copy of the most recent privacy notice for our office will be given to each patient upon their first visit to our office or their return visit on or after April 14th, 2003.

An acknowledgement that the patient has received our privacy notice is required under HIPPA regulations. To do this we will have each patient fill out and sign this form. It will then be placed in their medical record.

By signing below, I hereby acknowledge receipt of the Practice's Notice of Privacy Practices.

_____

Print Name

_____

Signature

_____

Date

If there is a revision to our privacy notice, we will promptly distribute and acknowledge this new notice of privacy practices. If you would like to authorize others to receive your sensitive health information, please list the names of the person and their relationship with you.

Name:	**Relationship:**
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____

_____ _____

Your Signature **Date**

2001 Marcus Avenue Suite E 130
Lake Success, NY 11042
Phone: (516) 352-2700
Fax: (516) 437-6904

Complete Care Dermatology
Mimi Bansal, MD

PQRS Submission Questionnaire

Name: _____ **DOB: _____**

Insurance: _____ **A/C#: _____** **Date: _____**

(FOR OFFICE USE)

1	Are you a new patient? Have you had any biopsy performed this year? Are you here for your biopsy results follow up appointment?									**Yes** **Yes** **Yes**	**No** **No** **No**
2	Have you Received the Influenza Vaccine for the current year? If no, do you have any medical condition that prevents you from receiving the Vaccine?									**Yes**	**No**
3	Have you received your Pneumonia Vaccine? If yes, when? _____									**Yes**	**No**
4	Have you updated your current medication list with your doctor?									**Yes**	**No**
5	Please circle your pain level on a scale of 1 to 10	**N/A**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9** **10**
6	Do you have history of any of the following conditions? a) Basal Cell Skin Cancer b) Squamous Cell Skin Cancer c) Melanoma Skin Cancer									 **Yes** **Yes** **Yes**	 **No** **No** **No**
7	If you answered "Yes" to any part of Question 6, have you been adequately treated for your skin cancer?									**Yes**	**No** **N/A**
8	Do you consume alcohol? If yes, how often? _____									**Yes**	**No**
9	Do you smoke? If yes, how many per day? _____									**Yes**	**No**

Patient's Signature _____ Date _____