GREENE DERMATOLOGY
RICHARD M. GREENE, M.D., P.C.
DERMATOLOGY AND DERMATOLOGIC SURGERY

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PLEASE COMPLETE BOTH SIDES OF PAGE

PATIENT INFORMATION

LEGAL NAME_____DATE OF BIRTH_____/_____/_____
FIRST MI LAST

ADDRESS_____
STREET CITY STATE ZIP

HOME PH (_____)_____CELL (_____)_____ WORK (_____)_____

EMAIL_____EMPLOYER NAME:_____

☐ MALE ☐ FEMALE SSN_____

PRIMARY CARE PHYSICIAN_____ REFERRING PHYSICIAN_____

SPOUSE'S NAME_____ EMPLOYER_____ PHONE_____

INSURANCE

NAME OF **PRIMARY** INSURANCE COMPANY_____ID#_____

SUBSCRIBER'S NAME_____**DOB** _____

NAME OF **SECONDARY** INSURANCE COMPANY_____ID#_____

SUBSCRIBER'S NAME_____**DOB** _____

NAME OF TERTIARY INSURANCE COMPANY_____ID#_____

SUBSCRIBER'S NAME_____**DOB** _____

RESPONSIBLE PARTY IF NOT SELF

☐ OTHER ☐ PARENT/GUARDIAN (please fill out pediatric section)

RESPONSIBLE PARTY NAME_____RELATIONSHIP_____

ADDRESS_____PHONE NUMBER (_____)_____

DATE OF BIRTH_____SSN_____

PEDIATRIC PATIENTS ONLY: Please check box for responsible party

☐ MOTHER'S NAME_____ EMPLOYER/WORK PH_____

(IF DIFFERENT) ADDRESS _____
STREET CITY STATE ZIP

☐ FATHER'S NAME_____ EMPLOYER/WORK PH_____

(IF DIFFERENT) ADDRESS _____
STREET CITY STATE ZIP

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information ("PHI"). I understand that I may request a copy of the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. 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 provided 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 operation. 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.

(CONTINUED ON BACK SIDE, PLEASE FLIP OVER)

★ **PART A: Authorization to disclose medical/financial information to individuals other than the patient, primary care physician and referring physician:**

I hereby authorize Dr. Richard M. Greene's office to disclose any pertinent medical and/or financial information to the family members, friends and/or doctors listed below in reference to my care or payment for such care:

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

Our office may contact you by telephone regarding appointments, financial and/or medical information. **Please check one of the following:

☐ Yes, it is okay to leave messages on my home and/or cell ☐ No, do not leave messages on my home and/or cell

Comments/Restrictions:_____

** Our office has the ability to send your appointment reminders via text message, **please check one of the following:**

☐ Yes, it is okay to text me an appointment reminder ☐ No, I prefer a phone call regarding my appointment

★ PART B: Notice of Privacy Practices Acknowledgement:

Acknowledgement signed by: _____

Printed Name – Patient or Parent/ Legal Guardian of patients 11 or younger

Signature: X_____Date_____

Patient or Parent/ Legal Guardian of patients 11 or younger

Relationship to Patient (if other than patient): _____

★ **PART C: MEDICAL HISTORY QUESTIONNAIRE**

1. Are you allergic to any medication(s)? _____yes _____no

If yes, please list the medications you are allergic to_____

2. Please list the names of medications that you are currently taking:

MEDICATION	DOSAGE	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Do you take aspirin or blood thinners? _____yes _____no

If yes, _____

(Name of medication)

5. Have you ever been treated for any form of cancer? _____yes _____no

If yes, was it metastatic? _____yes _____no

6. Do you smoke? ___yes ___no ___former smoker

7. Do you drink alcohol?

_____daily _____occasionally _____rarely _____none