Welcome to ProHEALTH Care Associates, LLP.

PATIENT REGISTRATION FORM

In order to serve you, we need the following information. Please print.

Today's Date:	**Thank you for selecting ProHEALTH Care Associates.**

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Gender:	Age:	Birth Date:

Social Security No.:	Preferred Language:	Marital Status: S M D W SEP	Student: ☐ Part Time ☐ Full Time

Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ White ☐ Decline to Answer ☐ Black or African American ☐ Two or More Races

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

Street Address:	Apt #	City/Town:	State:	Zip Code:	Home Phone No.:

Mobile Phone No.:	Email Address:	Work No.:

Name of Employer:	Address:	City/Town:	State:	Zip Code:

SPOUSE'S INFORMATION

Last Name:	First:	Middle:	Gender:	Age:	Birth Date:

Mobile Phone No.:	Work No.:	Social Security No.:

Employer:	Street Address:	City/Town:	State:	Zip Code:

PARENT INFORMATION

Complete the section below with your parent's information if you are a full time student covered under their health insurance.

Insured's Last Name:	Insured's First:	Middle:	Gender:	Age:	Birth Date:

Mobile Phone No.:	Work No.:	Social Security No.:

Employer:	Street Address:	City/Town:	State:	Zip Code:

EMERGENCY CONTACT

Name:	Relationship to Patient:

Primary Telephone No.:	Secondary Telephone No.:

PRIMARY CARE PHYSICIAN

Primary Care Physician Name:	
Street Address:	
City, State, Zip:	Telephone No.:

REFERRING PHYSICIAN

Referring Physician (if not same as PCP):	
Street Address:	
City, State, Zip:	Telephone No.:

Please provide the name/s and telephone numbers of any other doctors treating you at this time.

PHARMACY INFORMATION

Name of Pharmacy:	Address:	Telephone No.:	Fax No.:

HEALTH INSURANCE INFORMATION

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:

PRIMARY INSURANCE

Insurance Name:	Claims Address:	Telephone No.:	Group No.:
			ID No.:
Insured's Name (if not self, spouse or parent listed above):		Insured's S.S. No.:	Birth Date:

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:

SECONDARY INSURANCE

Insurance Name:	Claims Address:	Telephone No.:	Group No.:
			ID No.:
Insured's Name (if not self, spouse or parent listed above):		Insured's S.S. No.:	Birth Date:

WORKER'S COMPENSATION INFORMATION

Is the reason for this visit due to a work related accident? ☐ Yes ☐ No **If yes, you must complete this section.**

Date of Injury/Onset of Illness:	Employers Insurance Carrier Name & Address:
WCB Case No.:	Carrier Case No.:
Are you currently working? ☐ Yes ☐ No	Last Day Worked:

Briefly describe how and where patient's injury occurred:

NO FAULT INFORMATION

Is the reason for this visit due to a motor vehicle accident? ☐ Yes ☐ No **If yes, you must complete this section.**

Date of Accident:	Insurance Carrier Name:	Address:	
Policyholder's Name:	Policy No.:		Claim No.:
Relationship to Insured: ☐ Self ☐ Spouse ☐ Other:		Claims Adjuster:	Telephone No.:
Are you currently working? ☐ Yes ☐ No		Last Day Worked:	

Briefly describe how and where patient's injury occurred:

ATTORNEY INFORMATION

Law Firm Name:	Address:	Name of Attorney Handling Case:	Telephone No.:
			Fax No.:

AUTHORIZATION FOR RELEASE OF INFORMATION BY ProHEALTH Care Associates, LLP

I hereby authorize and direct the above named clinical practice, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such treatment. Upon my request for release of my medical records, I hereby authorize ProHEALTH Care Associates, LLP to furnish all records and results to the parties I specify.

PATIENT SIGNATURE: _____ **DATE:** _____/_____/_____

ASSIGNMENT OF BENEFITS

I hereby assign, transfer and set over to the above named clinical practice sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my medical costs of the care and treatment rendered to myself or my dependent in said practice. I understand I am responsible for any services not covered by my insurance. I accept responsibility for payment of my account.

PATIENT SIGNATURE: _____ **DATE:** _____/_____/_____

Patient's Name (Print): _____ Date of Birth: _____/_____/_____

As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the US Department of Health and Human Services office of Civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices, or in accordance with your wishes as stated below.

This waiver authorizes ProHEALTH Care Associates to send/give my medical information as noted:

Leave a voice mail recording including my Personal Health Information on my home telephone: ☐ Yes ☐ No

Leave a voice mail recording including my Personal Health Information on my cell phone: ☐ Yes ☐ No

Leave a voice mail recording including my Personal Health Information on my business phone: ☐ Yes ☐ No

Use of electronic communication systems (i.e. fax, electronic messaging) to transmit prescription, treatment, disorder related information, lab or other results: ☐ Yes ☐ No

Use of email to transmit treatment or disorder related information which may include a diagnosis, lab or other results sent to me, even if the email is not encrypted (not protected over the Internet. ☐ Yes ☐ No

Permit the individual stated below (Personal Representative) to receive prescriptions and/or test results: ☐ Yes ☐ No

Speak to a family member of my choosing (Personal Representative as designated below) regarding my Personal Health Information: ☐ Yes ☐ No

Name of Designated Personal Representative (PRINT):_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

On this date _____, I received and reviewed ProHEALTH's Notice of Privacy Practices, which describes how my medical information may be used and disclosed and explains how I can get access to this information.

I had an opportunity to raise questions regarding this policy and all of my questions have been answered.

The authorizations made above will remain effective until such time as I notify ProHEALTH Care Associates in writing, by certified mail, of requested changes.

_____ _____

Patient or Parent/Guardian Signature Today's Date

_____ _____

Patient Social Security Number Email Address

_____ _____

Patient Home Telephone Number Other Contact Number

Darren K. Mollick, M.D.
Anthony L. Wong, M.D.
Daniel M Siegel, M.D.
Diplomates of the American Board of Dermatology

Dermatology & Aesthetic Physicians of Long Island
A Division of ProHEALTH Care Associates, LLP

Long Island Skin Cancer & Dermatologic Surgery
A Division of ProHEALTH Care Associates, LLP
DERMATOLOGY AND DERMATOLOGIC SURGERY
MOHS MICROGRAPHIC SURGERY • LASER AND COSMETIC DERMATOLOGY

Cancellation and Referral Policy

CANCELLATIONS:

I _____, as of this date, _____, understand that if I do not cancel my appointment before the day of my scheduled appointment and do not show up, I will be charged a fee of $35.00, which I WILL pay when billed. I also understand that if I am scheduled for surgery or a procedure of any kind and do not cancel at least 24 hours in advance and do not show up, I will be charged a fee of $100.00, which I WILL pay when billed.

REFERRALS:

I _____, as of this date, _____, understand that it is my responsibility to know if my insurance requires referrals. It is also my responsibility to obtain a referral BEFORE the date of my appointment. I understand that if I show up for an appointment without a valid referral, I will NOT be seen and will need to reschedule. Further, I understand that it is not the office's responsibility to obtain my referral at any time, for any reason. I understand that disputing this with the receptionist or office manager will not change this policy and I will still have to reschedule my appointment if I show up without a valid referral.

By signing here I am stating that I understand and agree to the above policies. I also understand that if I do not sign this agreement, I will not be seen in this office. (If patient is a minor, please print the name of parent or guardian in place of patient's name below.)

Print: _____

Sign: _____

Date: _____

Darren K. Mollick, M.D.
Anthony L. Wong, M.D.
Daniel M Siegel, M.D.
Diplomates of the American Board of Dermatology

Dermatology & Aesthetic Physicians of Long Island
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DERMATOLOGY AND DERMATOLOGIC SURGERY
MOHS MICROGRAPHIC SURGERY • LASER AND COSMETIC DERMATOLOGY

Patient Name:_____ D.O.B:_____
Reason for visit:_____
LESION GROWING: Slow Fast Where on the body: _____
How long have you had it? (ie. days, months, years, don't know)_____
Medical History: (please circle all that apply)

PACEMAKER	HIV	SWOLLEN GLANDS
DEFIBRILLATOR	HEPATITS	HEADACHE
ARTIFICIAL HEART VALVE	ASTHMA	NIGHT SWEATS
HIP/KNEE REPLACEMENT When___	LUNG DISEASE	SUDDENWEIGHTGAIN/LOSE
HEART DISEASE	NERVE DAMAGE	EXCESSIVE URINATION
IRREGULAR HEARTBEAT	SEIZURES	COLD/HEAT INTOLLERANCE
HYPERTENSION	GLAUCOMA	EXCESSIVE THIRST
LEAKY VALVES	WEAKNESS	SKIN RASH/LESION
STROKE	DIZZINESS / FAINTING	DRY SKIN
DIABETES	ALCOHOL	CHANGING MOLES
ABNORMAL BLEEDING	SMOKING How much___	ABNORMAL SCARRING
RECENT OPERATION/HOSPITALIZATION	DRUGS	NUMBNESS
PREGNANT How many weeks___	SKIN CANCER	FEVER

BLOOD THINNERS: (CIRCLE ALL THAT APPLY)

FISH OIL	ASPIRIN	PRADAXA
VITAMIN E	PLAVIX	COUMADIN/WARFARIN

(OTHER)_____
_____
CURRENT MEDICATIONS **(NONE)** _____
_____
_____
_____
DRUG ALLERGIES? (Please list)_____
HISTORY OF MELANOMA? YES _____ NO _____ DATE: _____

FAMILY HISTORY OF:(PLEASE CIRCLE) MELANOMA SQUAMOUS CELL CARCINOMA BASAL CELL CARCINOMA ATYPICAL MOLES **NONE**
(Please identify relationship to self)_____

Print: _____
Sign: _____
Date: _____

• 40 Crossways Park Drive, Suite 102, Woodbury, New York 11797
• 994 West Jericho Turnpike, Suite 103, Smithtown, New York 11787
• 13405 Main Road, Mattituck, New York 11952
• 200 Old Country Road, Suite 140, Mineola, New York 11501
• 4 ProHEALTH / 3 Delaware Drive, 2nd Floor, Lake Success, New York 11042

Tel: (516) 921-SKIN (7546) • Fax: (516) 921-6460
Tel: (631) 864-MOHS (6647) • Fax: (631) 864-6001
Websites:
www.liskincancer.com
www.prohealthcare.com