MarieAnne Giardina-Beckett MD **Joanna Zurada MD** **PLEASE PRINT**

PATIENT INFORMATION

DATE____________________

LAST NAME _________________________________FIRST NAME________________________________

SEX: M F BIRTHDAY: ______________MARITAL STATUS_______ SS#________________AGE_____

ADDRESS____

STREET CITY STATE ZIP

HOME PHONE______________________CELL ____________________ E-MAIL_____________________

WORK PHONE________________________ HOBBIES____

OCCUPATION_________________________ REFERRED BY_____________________________________

BUSINESS NAME/ADDRESS____

EMERGENCY CONTACT____

NAME /RELATIONSHIP TEL #

PRIMARY DOCTOR_________________________________PHONE #______________________________

PHARMACY# ______________________

INSURANCE COVERAGE

INSURANCE CO. NAME__________________________________ID#_______________________________

SUBSCRIBER NAME________________________________SUBSCRIBERS BIRTHDATE_____________

RELATIONSHIP TO PATIENT ________________________SS#___________________________________

SUBSCRIBERS ADDRESS____

SUBSCRIBER EMPLOYED BY: ____

SECONDARY INSURANCE__________________________________ID#____________________________

YOU MAY DISCUSS MY MEDICAL FILE WITH THE FOLLOWING:

NAME:_____________________________________ RELATIONSHIP___________PHONE:__________________

NAME:_____________________________________ RELATIONSHIP___________PHONE:__________________

PLEASE READ:

I, THE UNDERSIGNED CERTIFY THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCLUDING THE DEDUCTIBLE, COINSURANCE, CO-PAYMENT, CHARGES FOR NON COVERED OR COSMETIC SERVICES AND COLLECTION FEES WHETHER OR NOT PAID FOR BY INSURANCE. I AM AWARE THAT A $10.00 SURCHAGE WILL BE APPLIED FOR BILLS DELIQUENT BEYOND 30 DAYS. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS. I ALSO CONSENT FOR THE OFFICE TO LEAVE CONFIRMATION OF APPOINTMENT AND TEST RESULTS ON THE TELEPHONE.

____

SIGNATURE OF RESPONSIBLE PARTY **DATE**

DERMATOLOGY MEDICAL HISTORY

Patient: ______________________________ Date: ____/____/____

Reason for today's visit: ______________________________

Family History

__ARTHRITIS __PSORIASIS __SKIN CANCER __MELANOMA

__ECZEMA __DIABETES __ASTHMA __CANCER

List all medications you are currently taking (including prescriptions, over the counter meds, vitamins, and herbals):

1. __________ 2. __________ 3. __________ 4. __________

5. __________ 6. __________ 7. __________ 8. __________

Are you allergic to any medications? __YES __NO If yes, list below: Adhesive Tape Allergy ____YES ____NO

1. __________ 2. __________ 3. __________

Have you ever had dental anesthesia (Novocain)? __YES __NO Any bad reaction? ___YES ___NO

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	YES	NO
Bronchitis	___	___
Emphysema	___	___
Asthma	___	___
Chronic Cough	___	___
Morning Cough	___	___
Shortness of Breath	___	___
Wheezing	___	___

Cardiovascular:	YES	NO
High Blood Pressure	___	___
Chest Pain	___	___
Heart Attack	___	___
Heart Murmur	___	___
Irregular Heartbeat	___	___
Phlebitis	___	___
Inflammation of vein	___	___
Blood clots	___	___
Pacemaker	___	___

Other Systemic:	YES	NO
Diabetes	___	___
Excessive thirst/hunger	___	___
Thyroid	___	___
Kidney	___	___
Bladder	___	___
Frequency/burning	___	___
Gastrointestinal	___	___
Stomach absorption disorder	___	___
Nausea, vomiting, diarrhea when taking antibiotics	___	___
Yeast infection when taking antibiotics	___	___
Arthritis/Joint Deformity	___	___
Arthralgia	___	___
Limited motion	___	___
Artificial joint	___	___
Convulsions, Epilepsy, or Seizures	___	___
Fainting	___	___

List any other diseases or conditions: ______________________________

List surgical procedures you have had in the last 6 months: ______________________________

Skin:

Have you ever had skin cancer? ___YES ___NO

Do you have a history of any specific skin diseases? ___YES ___NO If yes, __________

Do you have problems with healing? ___YES ___NO

Do you develop keloids? ___YES ___NO

Do you bleed easily? ___YES ___NO

Social History:

Do you drink alcohol? ___YES ___NO If yes ________ drinks per day

Do you use IV drugs? ___YES ___NO If yes, what? __________ How often? __________

Do you smoke? ___YES ___NO If yes, how much: __________

Have you had or have you been exposed to HIV(AIDS) ? ___YES ___NO Blood Transfusion ___YES ___NO

FEMALE PATIENTS: Are you pregnant? ___YES ___NO Due date: ___/___/___ Oral Contraceptives? __________

Onset of last menstrual period __________ # of Pregnancies: __________

Completed by: ___ Patient

___ Medical Assistant ______

______________________________ ___/___/___

Signed by Patient Date

______________________________ ___/___/___

Reviewed by Date

MarieAnne Giardina-Beckett MD
Joanna Zurada MD

Diplomate American Board of Dermatology
71 Union Ave Suite 108
Rutherford, NJ 07070
Telephone: 201-804-8900
Fax: 201-8048901

ACKNOWLEDGEMENT FORM
NOTICE OF PRIVACY PRACTICES

THE NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY

Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). The Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information
2. The right to request corrections to your information
3. The right to request that your information be restricted;
4. The right to request confidential communication
5. The right to a report of disclosures of your information; and
6. The right to paper copy of the Notice.

We want to assure you that your medical/protected health information is secure with us. The Notice contains information about how we will insure that your information remains private.

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have been made aware of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the office manager. I further understand that the practice will offer me updates to the NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way."

____

Patient or Representative Name (please print)

____

Patient or Representative Signature Date

MarieAnne Giardina-Beckett, M.D.
Shari Sperling, D.O.
Joanna Zurada, M.D.
71 Union Avenue Suite 108
Rutherford, NJ 07070
Phone: (201) 804-8900 Fax (201) 804-8901

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act – HIPPA. This Federal Law prohibits any staff member of MarieAnne Giardina-Beckett from discussing appointments, medications, test results or treatment plans with anyone other than the patient. Often this causes difficulty for some patients who would like family members or caretakers to obtain information for or about them. This becomes especially important if your spouse or adult children assist with making appointments for you or if you are a college student away at school and your parents assist you with prescriptions and appointments.

The law provides that you can permit one or more individuals to discuss your medical condition, confirm appointments or obtain results on your behalf. Below is a list which you may complete. Only those individuals listed may obtain information about you.

You may discuss my medical file with the following:

NAME OF INDIVIDUAL	RELATIONSHIP TO PATIENT	PHONE NUMBER

Please place a check mark next to the following methods we may use to contact you:

You may leave a message Regarding Appointments	Regarding Medical Information
Answering machine at home	
Anyone at home	
Work phone	
Cell phone	
Send post card regarding recall appt	

Patient or Guardian Signature________________________________Date________________________