PATIENT REGISTRATION FORM

elena JONESMD™
BOARD CERTIFIED DERMATOLOGIST

Phone: (212)-717-0352
Fax: (212)-996-5707
eljdermbilling@gmail.com

Date_____ Referral Source_____

Full Name (first) _____ Last_____
S.S. # _____
D.O.B. _____
Gender _____
Marital Status _____
Occupation _____ Employer_____
Home Address _____
_____
Home # (_____) -_____
Work # (_____)-_____
Mobile # (_____)-_____
Email _____
Emergency Contact _____
Emergency Phone _____
Pharmacy _____ Pharmacy #_____

I authorize the assignment of my insurance benefits directly to my physician. I will be personally responsible for any deductible, copay, coinsurance or unpaid balance. Should a referral be required by my insurance company, it is my responsibility to obtain this from my Primary Care Physician (PCP) and bring it on the day of my visit.
We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. We need to be notified 24 hours before your scheduled appointment. You will incur a fifty ($50) fee if the office is not informed via telephone or email.
In signing below, I authorize payment by credit card for services in the absence of payment by my health insurance company and for cancellation/no show policy. Please note that this will not compromise your ability to dispute your insurance company's determination of payment.

Type of Card _____
Credit Card Number _____
Expiration date _____
Security Code _____

Patient Signature_____ Date_____

PRIMARY INSURANCE: (COPY OF INSURANCE CARD REQUIRED)
Insurance Company: _____ID# _____
Group _____ Policy Holder's

Patient's Name _____ Age _____ Pt. # _____ Date _____
Allergies: _____
Current Medications: _____

Reason for Today's visit: (complaint):

_____

_____

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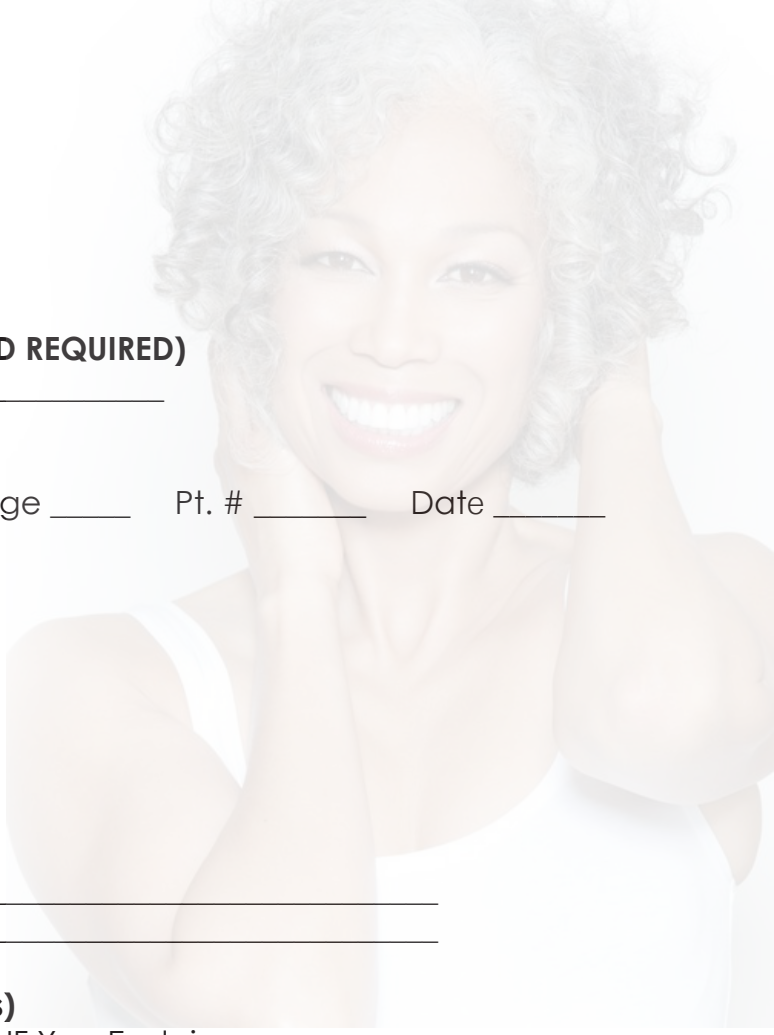

PRIMARY INSURANCE: (COPY OF INSURANCE CARD REQUIRED)
Insurance Company: _____ID# _____
Group _____ Policy Holder's

Patient's Name _____ Age _____ Pt. # _____ Date _____

Alergies:_____
Medical Conditions:_____

Reason for Today's visit: (complaint):

_____
_____
_____

Current or past problems with: (Review of Systems)

	YES	NO	IF Yes, Explain
Arthritis/Muscles/Joints			
Asthma			
Blood/ Bleeding Disorder(s)			
Cancer			
Diabetes			
Eyes			
Ears/Nose/Throat/Mouth			
General Health			
Headaches/Seizures			
Heart Disease			
Hepatitis			
Immune-Suppression(HIV, Bone marrow transplant)			
Kidneys			
Lungs			
Psychological Disorder(s)			
Skin			
Stomach/Bowel			
Thyroid			

Are you Pregnant? YES [ ] NO [ ] Are you planning to become pregnant? YES [ ] NO [ ]

Family History: Mother: Living/Deceased ___age Father: Living/Deceased ___age

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Check the following medical conditions that have occurred in your family:

Diseases	Mother	Father	Blood Relative
Allergies			
Arthritis			
Asthma			
Cancer			
Diabetes			
Eczema			
Hay Fever			
Heart disease			
High Blood Pressure			
Lung disease			
Malignant melanoma			
Psoriasis			
Skin Cancer			
Tuberculosis			

Do you live alone? YES [ ] NO [ ]
Do you smoke? YES [ ] NO [ ]
Frequency? _____

Do you drink Alcohol? YES [ ] NO [ ]
Do you use recreational Drugs? YES [ ] NO [ ]
Frequency? _____

Reviewed _____ Date _____ Update _____

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New patient consent to Use and Disclosure of health information for Treatment, Payment or healthcare operations

I, _____, understand that as part of my healthcare, Elena L. Jones, M.D., P.C., originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment.
I understand that this information serves as:
A basis for planning my care and treatment
A means of communication among the health professionals who contribute to my care
A source of information for applying my diagnosis and surgical information to my bill
A means by which a third-party payer can verify that services billed were actually provided
A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals
I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:
The right to review the notice prior to signing this consent
The right to object to the use of my health information for directory purposes, and,
The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations
I understand that Elena L. Jones, M.D., P.C., is not required to agree to the restrictions requested.
I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.
I further understand that Elena L. Jones, M.D., P.C., reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Elena L. Jones M.D., P.C., change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S mail or, if I agree, email).I wish to have the following restrictions to use or disclosure of my information:

_____

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including via Fax.

I fully understand and accept [ ]/decline [ ] the terms of this consent. (Check one that applies)

_____ _____

PATIENT'S SIGNATURE DATE

FOR OFFICE USE ONLY

[ ] Consent received by _____ on _____.
[ ] Consent refused by patient, and treatment refuse as permitted.
[ ] Consent added to patient's medical record on _____.