CAMERON K. ROKHSAR, MD PC

(516) 512-7616 or (212) 285-1110

Patient Information as of _____ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? ☐ No ☐ Yes E-mail (REQ) _____

Contact Restrictions: _____ Drivers License # (include State) _____

Age _____ Birthdate (REQ) ___/___/___ SS# (REQ) ___-___-___ Sex ☐ Female ☐ Male

Marital Status ☐ Single ☐ Married to: _____ ☐ Other: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ☐ Yes ☐ No

Address _____
Street & Suite # City State Zip

Emergency Contact

_____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt # City State Zip

Referring Physician Name _____ Phone Number _____

Referring Physician Address _____

Primary Care Physician Name _____ Phone Number _____

Primary Care Physician Address _____

Pharmacy Name _____ ***Address*** _____ ***Phone*** _____

Primary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ☐ No ☐ Yes Copay? ☐ No ☐ Yes, $ _____

Insured: Name _____ DOB _____ Employer _____

Secondary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ☐ No ☐ Yes Copay? ☐ No ☐ Yes, $ _____

Insured: Name _____ DOB _____ Employer _____

I understand that office visit charges are payable on the day service is rendered. I authorize the Dr. to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between the Dr. and myself. I have read and completely understand the HIPPA compliance form. If I have any questions regarding privacy practices I will contact Dr. Rokhsar's office.

Signature _____ **Date** _____

NEW YORK COSMETIC, SKIN
& LASER SURGERY CENTER

CAMERON K. ROKHSAR, MD, FAAD, FAACS
Dermatology, Laser & Cosmetic Surgery, Mohs Surgery

Name: _____ **Date:** _____ **Tel. No:** _____

Physician: **Dr. Cameron Rokhsar**

In addition to the reason for my visit today, I am interested in learning more about the items checked below:

____ **Blepharoplasty(eyelift)**
____ **EyeLid Rejuvenation**
____ **Liposculpture/Liposuction**
____ **Mini-Face Lift**
____ **Hair Restoration**
____ **Fat Transfer**
____ **Leg Vein Treatment**
____ **Photofacials**
____ **VelaShape for Cellulite**

____ **Laser Treatment of Acne**
____ **Laser Treatment of Acne Scars**
____ **CO2 Laser Resurfacing**
____ **Thermage** (non-surgical skin tightening)
____ **Laser of Red Spots**
____ **Laser of Brown Spots**
____ **Laser Hair Removal**
____ **Fraxel Laser Treatment**
____ **Laser Tatoo Removal**

____ **Non Surgical Nose Job**
____ **Non Surgical Eye Lift**
____ **Lip Enhancement**
____ **Non Surgical Body Contouring**
____ **Botox**
____ **Radiesse**
____ **Restylane**
____ **Sculptra**
____ **Microdermabrasion**
____ **Chemical Peels**

Please provide us with your email address: _____

Please feel free to share with us any additional confidential comments or questions you may have:

_____

_____

_____

_____

_____

_____

Thank you for your time and interest

901 Stewart Avenue, Suite 240
Garden City, NY 11530
Phone (516) 512-7616
Fax (516) 512-7617

260 East 66th Street
New York, NY 10065
Phone (212) 285-1110

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981 Stewart Avenue, Suite 240
Garden City, NY 11530
Phone: (516) 512-7616
Fax: (516) 512-7617

260 East 66th Street
New York, NY 10065
Phone: (212) 288-1110

PATIENT MEDICAL HISTORY

Name: _____ Height: _____ Weight: _____ Date: _____

Please check and, if applicable, circle, any of the following conditions you currently have or have had in the past.

_____ Skin Cancer (type: _____)
_____ Other Cancer (type: _____)
_____ Heart Disease (heart attack, angina, rheumatic fever, heart valve replacement, atrial fibrillation, mitral valve prolapse)
_____ High Blood Pressure
_____ Pacemaker
_____ Stroke or TIA (transient ischemic attack)
_____ Blood Clots
_____ Immune Deficiency
_____ Endocrine Disorder (diabetes, Cushings)
_____ Artificial Joints
_____ Blood/Lymph Gland Disorder (anemia, leukemia, low Platelets, lymphoma, hemophilia, sickle cell)
_____ Taken Accutane (for acne treatment)
_____ Neurologic Disorder
_____ Frequent Skin Infections
_____ Ear Disease (deafness, Meniere's, acoustic neuroma
_____ Eye Disease (glaucoma, cataracts, blindness)
_____ Duodenal or Peptic Ulcer
_____ Intestinal Disease (irritable bowel, ulcerative colitis, Crohn's)
_____ Liver or Gall Bladder Disease
_____ Lung Disease (tuberculosis, asthma, emphysema, pleurisy)
_____ Kidney Disease
_____ Urinary or Bladder Problem/Infection
_____ Arthritis, Joint, Muscle or Bone Disease (lupus, Raynauds, scleroderma)
_____ Radiation Treatment _____ Chemotherapy
_____ Emotional or Psychiatric History

- Have family members had: ____ Melanoma _____ Insulin-Treated Diabetes _____ Excessive Scarring ____ Cancer (type: _____)
- Do you: _____ Smoke (cigarettes, cigars, pipes) _____ socially drink alcohol (_____ drinks/week) _____ Use street drugs (type: _____)
- Please circle if you take any of the following on a Regular basis:
  Coumadin Aspirin Vitamin E Garlic Tablets Ginkgo Biloba Ginseng Ginger
- Do you have any allergies to any medications (please circle) YES or NO, if yes please list medications and your reaction to them:

_____

- Please circle if you have ever had an allergy or problem with any of the following and indicate on the line below you reactions:
  Local Anesthetic Epinephrine (Adrenaline) Latex Adhesives/Band-aids Antibiotic Ointment (i.e. – Neosporin, Bacitracin)

_____

- Have you or any family member had problems with anesthesia? NO YES _____
- Have you ever had any problems with sulfites, commonly found in red wines and salad bars? NO YES _____
- Please list any prior hospitalizations & surgeries: _____

_____

FOR WOMEN ONLY: Do antibiotics cause you to have yeast vaginitis? _____ Are you pregnant or nursing? _____ Have you missed you last menstrual period? _____ Are you planning a pregnancy? _____ Date of last mammogram? _____
** Please inform us if any of these become true during the course of your treatment at subsequent visits.*

- If a spouse, parent, child, sibling or friend were to ask questions reguarding your care, do you authorize Dr. Cameron Rokhsar to discuss your care? If so, with whom? (Please write names & relationship to you) _____

_____

- Do you allow us to leave medical information, such as laboratory results or answers to medical questions that were asked of us, on your voice mail or answering machine? NO YES

Signature _____ **Date** _____

PRIVACY AGREEMENT

Dr. Cameron Rokhsar and The New York Cosmetic Skin & Laser Surgery Center (collectively labeled "*Physician*") agree to provide treatment to the below named patient. The Physician takes pride in being able to extend a greater degree of privacy than is required by law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, physicians are forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Physician believes this is improper and may not be in the patients' best interest. Accordingly, Physician agrees not to provide medical information for the purpose of marketing directly to Patient. Regardless of legal privacy loopholes, Physician will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of "rating sites" in cyberspace, many fail to provide useful information. Let's get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

Nothing in this Agreement prevents a patient from posting commentary about the Physician - his practice, expertise, and/or treatment - on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if Patient prepares such commentary for publication on web pages, blogs, and/or mass correspondence about Physician, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Physician for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary.

This Agreement shall be in force and enforceable for a period of five years from Physician's last date of service to Patient. As a matter of office policy, Physician is requiring all patients in its practice sign the Mutual Agreement so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Physician's patients. Further, this Agreement will survive for a minimum of three years beyond any termination of the Physician-Patient relationship.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

PRINT NAME: SIGNATURE: DATE:

NEW YORK COSMETIC, SKIN
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CAMERON K. ROKHSAR, M.D., F.A.A.D., F.A.A.C.S

Cancellation Policy for Appointments

Any time you are unable to keep your appointment, we would appreciate a call in advance from you so that we may cancel your appointment and use the appointment time for another patient. This serves as notice that if you fail to give us a 48-hour notice of cancellation for an appointment, there will be a $75.00 cancellation fee billed to your account that is non-covered by your insurance. You will bear complete financial responsibility for this fee.

I understand Dr. Rokhsar's appointment cancellation policy and understand my responsibility to plan appointments accordingly and notify the office appropriately if I have difficulty fulfilling my scheduled appointments.

_____ _____

Patient Signature Date

Credit Card Policy

A valid photo ID is required when paying by credit card.
We apologize for any inconvenience. Thank you.

_____ _____

Patient Signature Date