MICHELE S. GREEN, M.D.

Name____
Last First Middle initial

Address____
Number Street Apt# Town, State Zip

Home__________________ Cell__________________ Email______________________
Area Code Number Area Code Number

Please Circle: Preferred Contact Number Home Cell Work Instagram____________________

Single Married Divorced Widowed Male Female

Birth Date______________________ Birth Place_______________________________

Age Last Birthday______________ Social Security Number________________________

Have you ever been a patient in this office? ______ Referred by: _________________________
Physician, Real Self, Google, Internet, Other

Required Pharmacy Name_________________ Required Pharmacy Number______________

Required Pharmacy Address ____

Name & Telephone of Internist? ____

Medical Insurance Name_________________ Insurance Address __________________________

Primary Care Holder's Name _________________ Birth Date _______________________

Insurance ID number_____________________ Group number ____________________

Occupation____________________Business Name__________________________________

Business Address____
Number Street City State Zip
Business Phone______________________
Area Code Number
Emergency Contact________________________ Phone Number__________________
Name and Relationship Area Code Number

Emergency Contact Address____
Number Street City State Zip

____ __________________
Patient's Signature Date

Please note Dr. Green is not contracted with any insurance company. Please contact your individual insurance carrier to confirm what your individual out of network benefits are. The initial office visit is $300.00. All additional procedures performed will be an additional charge per procedure. A 24-hour notice is required for cancellation otherwise patient is responsible for a $100.00 cancellation fee. Payment is due when services are rendered.

QUESTIONNAIRE

To help give you the best possible care, please carefully complete all questions on this form.

A. HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING:

1. Duodenal or peptic ulcer	yes	no
2. Other intestinal disease or colitis	yes	no
3. Liver disease or gall bladder disease	yes	no
4. Lung disease	yes	no
5. Heart disease	yes	no
6. High blood pressure	yes	no
7. Stroke	yes	no
8. Kidney disease	yes	no
9. Urinary or bladder problem or infection	yes	no
10. Venereal disease	yes	no
11. Blood disorder or lymph gland disorder	yes	no
12. Eye disease (glaucoma, cataract)	yes	no
13. Arthritis, joint problem, bone disease	yes	no
14. Thrombophlebitis	yes	no
15. Cancer	yes	no
16. Neurological disorder	yes	no
17. Frequent infections	yes	no
18. Emotional or psychiatric problem	yes	no

B. HAVE YOU OR ANY MEMBERS OF YOUR FAMILY (Specify Who) HAD:

1. Asthma	yes	no
2. Hay fever	yes	no
3. Eczema	yes	no
4. Hives	yes	no
5. Diabetes	yes	no
6. Psoriasis	yes	no
7. Skin cancer	yes	no
8. Glaucoma	yes	no
9. Other skin conditions (specify)	yes	no

C. HAVE YOU EVER HAD?

Difficulty with the healing of wounds		
2. Overgrown scars or keloids	yes	no
3. Allergy to local anesthetics	yes	no

D. HAVE YOU PREVIOUSLY HAD A SKIN PROBLEM OR BEEN UNDER THE CARE OF A DERMATOLOGIST? IF YES, DESCRIBE:

____

E. HAVE YOU EVER HAD RADIATION? **yes no**

F. DO YOU TAKE ANY MEDICINES OR OVER-THE-COUNTER PREPARATIONS OR REMEDIES? **yes no**
PLEASE LIST____

G. ARE YOU ALLERGIC TO ANY MEDICINES? **yes no**
IF YES, PLEASE LIST:____
____

H. PRIOR HOSPITALIZATIONS AND SURGERY (Please give dates):
____
____

I. FOR WOMEN ONLY

1. **Have you had vaginal yeast infections?** **yes no**
2. **Are you pregnant?** **yes no**
3. **Are you currently planning a pregnancy?** **yes no**

Please inform Dr. Green at any time if you do plan to or become pregnant during your treatment period.

At the time of your first visit to this office, it is necessary for your entire skin to be examined. This will enable Dr. Green to see not only the particular skin condition for which you are consulting us, but also other skin problems of which you may not be aware.

You will be provided with a proper gown for your examination.

If for any reason you do not wish to have such a general examination of your skin, please tell Dr. Green and she will make a note on your chart regarding your wishes.

DATE___________________________

SIGNATURE____________________________________

MICHELE S. GREEN, M.D.
156 EAST 79TH STREET
NEW YORK, NEW YORK 10075
PHONE (212) 535-3088
FAX (212) 535-4012

DATE: ___________________

DEAR PATIENT IN ORDER TO HELP YOU KEEP YOUR MEDICAL HISTORY UP TO DATE PLEASE LIST ALL PHYSICIANS YOU WOULD LIKE US TO SEND YOUR PATHOLOGY AND LAB REPORTS TO:

To: ____________________________________

Address: ______________________________

Telephone: ____________________________

To: ____________________________________

Address: ______________________________

Telephone: ____________________________

____

Signature **Print**

MICHELE S. GREEN, M.D.
156 East 79th Street, Suite 1B
New York, NY 10075
(212) 535-3088

OFFICE POLICY

It is our office policy to have 24 hour cancellation notice otherwise an office visit fee of $100.00 will apply.

Missed appointments without notification will automatically be charged an office visit fee.

Payment is expected at the time of visit. After 90 days all outstanding bills will automatically be forwarded for collection.

All bounced checks will incur a $20.00 fee.

All unpaid balances will accrue a finance charge of 1.5% per month and a $3.00 billing charge. I hereby authorize Dr. Michele S. Green, M.D., P.C. to charge to the below account, any outstanding balance. In the event that fees are not paid as delineated above, I agree to pay any and all collection and/or attorney's fees incurred.

Signature of Patient or Guardian____________________________________

Method of Payment: MC________**VC**___________**AMEX**_____________

Credit Card Acct. #:________________________________**Exp. Date:**________

Driver's License #:__________________________**State:**________**Exp. Date**______

MICHELE S. GREEN,
M.D.
DERMATOLOGY AND
DERMATOLOGIC
SURGERY

156 East 79th Street – Suite 1B
New York, N.Y. 10075

(212) 535-3088
Fax (212) 535-4012

Please note Dr. Green is not contracted with any insurance company. Please contact your individual insurance carrier to confirm what your individual out of network benefits are. The initial office visit is $300.00. The follow up office visit is $200.00. Any additional procedure performed will be an additional charge per procedure.

If you have decided to have a complete skin examination, we would like you to be aware that for each mole removal there is a fee of $400. The mole is then sent to the laboratory for examination and you will receive a separate invoice from the pathology lab that is independent of our office.

The following list is a list of the laboratories and the insurances which they contract with. Our office sends Dermatology (biopsy results) to the Ackerman Academy and Blood/Cultures to Quest and LabCorp. If your health insurance does not cover these laboratories you may choose a different lab to send your specimens to. Please make Dr.Green or her assistant aware of your choice at the time of your visit.

Thank you very much for your assistance.

________________ ________________
Patient's Signature Date

Michele S. Green, M.D.
156 East 79th Street Suite 1B
New York, NY 10075

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Acknowledgement

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information ("PHI") about you. You have the right to review our Notice and ask questions about our privacy practices. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by calling (212) 535-3088. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you acknowledge that you have received our Notice of Privacy Practices.

____
Name of Patient

____
Signature of Patient

____
Date

MICHELE S. GREEN, M.D.

DERMATOLOGY AND
DERMATOLOGIC
SURGERY

156 East 79th Street – Suite 1B
New York, N.Y. 10075

Tel: (212) 535-3088
Fax: (212)535-0279

Medical Photography Consent Form

PATIENT CONSENT

First Name ______ Last Name ______ DOB ______

I consent to medical images and/or videos to be made of me. I agree that duplicates may be made for the referring doctor.
By signing this form below I confirm that this consent form has been explained to me in terms which I understand.

I consent for these photographs and/or videos to be used in medical publications, including medical journals, textbooks, and online/offline electronic publications. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs and/or videos will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

I agree that the images may be:	**YES**	**NO**
…placed in my medical record for future treatment	___	___
…electronically emailed to my treating health professional	___	___
…used by health professionals for education and training	___	___
…used in paper or electronic health publications	___	___
…used in commercial broadcast	___	___
…used in marketing materials	___	___
…used in internet or for marketing	___	___

By signing below, I confirm that I understand this consent form.

Signature of Patient ______ **Date:** ______

Signature of Doctor/Health Professional/Staff (Witness) ______ **Date** ______