DONALD T. LEVINE, M.D., F.A.C.S.
75 NORTH BROADWAY
NYACK, NY 10960

PATIENT INFORMATION **DATE: _____**

FIRST NAME: _____ M.I.: ____ LAST NAME: _____
SEX: MALE: _____ FEMALE: _____ DATE OF BIRTH: _____
SOCIAL SECURITY NUMBER: _____ RACE: _____
PREFFERED LANGUAGE: _____

ADDRESS: _____
HOME PHONE: _____ WORK PHONE: _____
CELL PHONE: _____ EMAIL: _____

REFERRING PHYSICIAN: _____ FAMILY PHYSICIAN: _____
PHARMACY (NAME & ZIP CODE): _____

EMPLOYMENT INFORMATION:
COMPANY NAME: _____ PHONE: _____
ADDRESS: _____ OCCUPATION: _____

WHO IS RESPONSIBLE FOR YOUR ACCOUNT? (CHECK. IF SELF, IGNORE SECTION)
SPOUSE: _____PARENT: _____
NAME: _____ PHONE: _____
ADDRESS: _____
EMPLOYER: _____ PHONE: _____

PRIMARY INSURANCE:
INSURED PARTY: _____ RELATIONSHIP: _____
DATE OF BIRTH: _____ SOCIAL SECURITY #: _____
INSURANCE COMPANY: _____
ADDRESS: _____
ID: _____ GROUP #: _____

FEES AND PAYMENTS:
PAYMENT MUST BE MADE AT THE TIME OF VISIT UNLESS PRIOR ARRANGEMENTS WERE MADE. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-PAYMENT OR ANY OTHER BALANCE NOT PAID FOR BY YOUR INSURANCE COMPANY.

THE SIGNATURE ON FILE IS MY AUTHORIZATION FOR THE RELEASE OF INFORMATION NECESSARY TO PROCESS MY CLAIM. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PHYSICIAN NAMED OF THE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

PATIENT SIGNATURE: _____ DATE: _____
(PARENT OR GUARDIAN IF MINOR)

PATIENT MEDICAL HISTORY

Name: _____Date: _____ D.O.B.: _____ Age: _____
Referred By: _____
Do you have any Facial Plastic or Cosmetic concerns? _____

	Y	N	Describe		Y	N	Describe
EARS				**ALLERGIES**			
Hearing Loss				Allergies to medications			
Tinnitus (ringing)				Environmental (dust, mold, etc.)			
Vertigo, dizziness				Pets, food, chemicals			
Pressure				Other immunologic problems			
Itching				**GASTROINTESTINAL**			
Pain				GERD/heartburn			
Drainage				Stomach problems			
NOSE				Bowel disease			
Nasal congestion				**GENITOURINARY**			
Post-nasal drip				Urinary tract infections			
Runny nose				Kidney disease			
Deviated septum				Prostate disease			
Decreased smell				Currently pregnant?			
Bleeding				**SKIN (circle if applies)**			
THROAT				Eczema, Psoriasis, Rashes, Hives			
Sore throat				Keloid scarring			
Excessive throat clearing				Herpes/Cold sores			
Hoarseness				Other skin problems			
Laryngitis				**MUSCULOSKELETAL**			
Other throat problems				Arthritis			
MOUTH PROBLEMS				Fibromyalgia			
CIRCULATION PROBLEMS				Other muscle/bone problems			
Heart disease				**EYES (circle if applies)**			
High blood pressure				Glaucoma, cataracts, poor vision			
High cholesterol				Other vision problems, itching			
RESPIRATORY				**NEUROLOGICAL**			
Asthma				Stroke			
Wheezing				**Seizures**			
Shortness of breath				**Pain**			
Cough				**Headaches/Migraines**			
Emphysema				**Other neurological problems**			
Other breathing problems				**ENDOCRINE**			
Hematologic				**Diabetes**			
Anemia				**Thyroid Disease**			
Bleeding				**Other hormone problems**			
Other blood/lymph probs				**Infectious Disease** (circle if applies)			
Psychiatric illness				Fever, Lyme, EBV, TB, Hepatitis, HIV			

List **previous surgeries** (include dates): _____

Do you have **family history** of: ☐ heart disease ☐ high blood pressure ☐ cancer ☐ diabetes
☐ infectious disease ☐ environmental allergy ☐ food allergy

If yes, briefly describe: _____
What is your current height? _____ Your current weight? _____

Current Medications (Please include vitamins, supplements, and over the counter drugs and dosages). _____
_____
_____

Habits: Tobacco (Yes) | How much do you smoke per day? _____ How many years have you smoked? _____
Alcohol (Yes) | Approximate amount per week? _____ Type: _____ Drug Use (Yes) Amount? _____

DONALD T. LEVINE, M.D., F.A.C.S.
HIPPA NOTICE OF PRIVACY PRACTICES

THIS MUST BE COMPLETED BY PATIENT OR REPRESENTATIVE

Patient Name: _____

YES I AM AWARE OF THE HIPPA PRIVACY NOTICE (Please check) ☐

I give permission to have information left on my answering machine. YES_____ NO_____

I give permission to send me appointment reminders and messaging via SMS mobile texting or voice telephone calls in addition to email appointment reminders. YES _____ NO _____

I give permission to release information regarding myself to:
(Please list family members, friends, doctors)

_____

_____

_____

I acknowledge receipt of this notice.

Patient or signature: _____

Date: _____

If you are signing as the patient's representative, print your name:

_____

NOTICE OF PRIVACY PRACTICE

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the notice.

_____ _____
Patient Name (Print) Date

_____
Parent or Authorized Representative

_____
Signature

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that, if you must cancel your appointment, you provide at least two (2) weekdays notice. This will enable another person who is in need of an appointment to be scheduled in that appointment slot. With cancellations made less than two (2) weekdays notice, we are unable to offer that slot to other people.

Appointments which are cancelled with less than two (2) weekdays notification will be subject of a $50.00 cancellation fee.

Patients who do not show up for their appointment without a call to cancel their appointment will be considered a *no show*.

Patients who *no show* will be subject to a $50.00 fee.

My practice firmly believes that good physician/patient relationship is based upon understanding and good communication.

Please sign that you have read, understand and agree to this Cancellation and No Show policy.

_____ _____

Patient Name (Please Print) Date