Bruce P. Robinson, M.D., F.A.A.D.

Diplomate American Board of Dermatology
121 East 60th Street, Second Floor
New York, New York 10022
www.BruceRobinsonMD.com
(212) 750 - 7121

Date: _____ New: _____ Update: _____

Patient's Last Name:_____ First:_____ MI: _____

Address:_____ Apt. #: _____ E-Mail: _____

City:_____ State: _____ Zip Code: _____

Home Telephone:_____ Cell:_____ Work: _____

Date of Birth:_____ Age:_____ Social Security #: _____

Marital Status:_____ Name of Spouse:_____

Patient's Gender:_____ Patient's Occupation: _____

Patient's Employer:_____ Address: _____

Person to contact in case of emergency: _____

Relationship:_____ Telephone #:_____

Whom may we thank for referring you? _____

Physician Name, Address and Telephone: _____
If you have been referred by a physician, a consultation will be performed and a consult letter sent to the referring physician.

Primary Insurance:_____ Secondary Insurance: _____

Identification #:_____ Identification #: _____

Name of Insured:_____ Name of Insured: _____

Date of Birth:_____ Date of Birth: _____

I hereby assign my insurance benefits to be paid directly to the physician in this office. I am financially responsible for non-covered services. I hereby authorize the release of medical information related to the services received in this office. Patient is responsible for informing our practice of any change in health insurance plans.

I acknowledge that the office of Dr. Robinson has given me (the patient) the contact information for LabCorp, Quest, and AmeriPath.

_____
Patient or Guardian Signature

Our office offers the convenience of having a credit card on file. Balances, co-payments, co-insurance, deductibles and cosmetic procedures for yourself as well as dependent's can be charged to your credit card with written authorization. By filling in the information below, you will be giving your consent to bill your c.c. for current and/or future charges. Your signature will therefore represent a pre-authorized order. Our office will always notify you by sending you a paid receipt.

Credit Card: Amex/Visa/MC *(Circle One)* Card #: _____ Security Code: _____

Expiration Date: _____

Signature of Credit Card Holder: _____

Print Name: _____

Billing address for this credit card: _____

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Current everyday smoker? _____ Current some days smoker? _____ Former smoker? _____

Never smoked? _____ Smoker, current status unknown_____ Unknown if ever smoked _____

Start date_____ Quit date_____ Cessation counseling offered_____ Date offered _____

Please list current medications: _____

_____

Please list allergies to any oral or topical medications: _____

Primary reason for appointment (list single problem here): _____

How long have you had this problem? _____

Have you received treatment for this problem?_____ If so, please describe:_____

Was treatment helpful?_____ Problems with treatment: _____

_____

How do you currently care for the skin of the involved area? _____

_____

Do you have other skin problems you would like evaluated?_____

_____

PLEASE NOTE: These problems may require a second appointment. If you have more than one problem treated during this visit, your insurance may refuse payment. There is an increase in skin cancer, including melanoma (mole cancer). The doctor recommends a yearly skin exam to evaluate moles.

If you have not had moles checked by a dermatologist, would you like to have them checked for melanoma?
Yes_____ No_____

Do you have any of the following? History of Rheumatic Fever: Yes_____ No_____

Heart valves or joints replaced: Yes_____ No_____ Mitral Valve Prolapse: Yes_____ No_____

Are you take steroids or blood thinner? Yes_____ No_____

Have your or any blood relatives had melanoma? Yes_____ No_____

Are you planning to get pregnant, currently pregnant, or nursing? Yes_____ No_____

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Is there anything about your medical history which would be useful or important for the doctor to know?

_____

_____

In order to ensure we are meeting our patient's cosmetic needs, we ask that you complete the following questionnaire. Please check all that apply.

These areas are a concern or interest to me:

c Fine lines and wrinkles

c Brown/Age/Sun spots

c Red Spots

c Broken Capillaries

c Acne Scars

c Leg Veins

c Thin Lips

c Fillers: Juvederm, Radiesse or Restylene

c Tattoo Removal

c Blue veins around eyes

c Sun Damage

c Anti-aging creams

c Removal of Pencil Tattoo

c Wrinkles on forehead

c Chemical Peels

c Fraxel Laser

c Lines around the nose and mouth

c Tired looking or uneven skin tone

c Unwanted hair-bikini, underarms, lip, chin

c Dark circles or puffiness of eyes

c Surgical Scars

c Blood vessels around nose

c Lines around mouth, lips and eyes

c Excessive Sweating-underarms/palms/forehead/lip

c Longer Eye Lashes

c Aging Hands/Veins on Hands

c Rough textured skin

c Moisturizing creams

c Removal of Eyebrow Tattoo

c Wrinkles adjacent to the eyes (crow's feet)

c Botox

Thank you for taking the time to allow us to better understand your concerns. Please do not hesitate to discuss your concerns with Dr. Robinson. You can also obtain additional information and before and after pictures by visiting our website www.BruceRobinsonMD.com

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NO-SHOW AND PAYMENT COLLECTION OFFICE POLICY

Dear Valued Patient:

Please be advised that we require no less than 24 hours notice whenever an appointment is cancelled. Patients are billed for NO-SHOW appointments. The current NO-SHOW fee is $50.00.

Insurance companies are not responsible for NO-SHOW bills. In the event that you realize you won't be able to keep an appointment during the weekend, you should leave a message cancelling your appointment with our service. Be sure to note the name of the service operator. Again, 24 hours notice is required for cancellations. If you cancel an appointment with our office staff, you should note her name as well.

All payments and co-payments are due at the time of service to avoid a $5.00 surcharge fee.

We thank you in advance for your cooperation.

This form must be signed before you see your physician.

_____ _____
Please Print Name Date

_____ _____
Signature Date

_____ _____
Witness Date

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Dr. Robinson may use and disclose protected health information about me to carry out treatment and conduct payment and health care operations. Please refer to Dr. Robinson's Notice of Privacy Practices for a more complete description of such uses and disclosures. It is available upon request.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Robinson reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Robinson at 121 East 60 Street, New York, NY 10022.

With my consent, Dr. Robinson may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment and to conduct payment and healthcare operations such as appointment reminders, insurance items, and any call pertaining to my clinical care including laboratory results among others.

With my consent, Dr. Robinson may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminder cards and patient statements. I have the right to request that Dr. Robinson restrict how he uses or discloses my Protected Health Information to carry out treatment, payment and healthcare operations.

However, the practice is not required to agree to my requested restrictions, but if it does it is bound by this agreement. By signing this form I am consenting to Dr. Robinson's use and disclosure of my Protected Health Information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior agreement. If I do not sign this consent, Dr. Robinson may decline treatment to me.

_____ _____
Signature of PATIENT or Legal Guardian Date

_____
Print PATIENT Name or Legal Guardian Name

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I ACCEPT and authorize Bruce Robinson M.D. and its affiliate The Dermatology Practice of Bruce Robinson M.D. and it's staff permission to use and publish the likeness of me in a photograph, video, or other digital media including social media ("Photo/Video") including my name and any quote in any and all of its publications, including press releases, marketing materials and web-based publications, without payment or other consideration.

I understand and agree that all Photos/Videos will become the property of Bruce Robinson MD and it's affiliate The Dermatology Practice of Bruce Robinson M.D..

I hereby irrevocably authorize Bruce Robinson MD and its affiliate The Dermatology Practice of Bruce Robinson M.D. to edit, alter, copy, exhibit, publish, or distribute these Photos/Videos for any lawful purpose.

In addition, I waive any right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the Photo/Video.

I hereby hold harmless, release, and forever discharge Bruce Robinson M.D. and it's affiliate The Dermatology Practice of Bruce Robinson M.D., its contractors and its employees from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I HAVE READ AND UNDERSTAND THE ABOVE PHOTO AND VIDEO RELEASE FORM. I AFFIRM THAT I AM AT LEAST 18 YEARS OF AGE, OR, IF I AM UNDER 18 YEARS OF AGE, I HAVE OBTAINED THE REQUIRED CONSENT OF MY PARENTS/GUARDIANS AS EVIDENCED BY THEIR SIGNATURES BELOW:

COMPLETE ONLY ONE SIDE. PLEASE PRINT CLEARLY

I ACCEPT and AUTHORIZE Bruce Robinson M.D. and its affiliate The Dermatology Practice of Bruce Robinson M.D.to take or publish any photographs or videos of me.

Patient
Name:_____

Signature: _____

Date:_____ (Patient or Responsible Party)

Printed
Name: _____
(Patient or Responsible Party)

Signature:_____

Date: _____

I DECLINE and do not authorize Bruce Robinson M.D. and it's affiliate The Dermatology Practice of Bruce Robinson M.D.to take or publish any photographs or videos of me.

Patient
Name:_____

Signature: _____

Date:_____ (Patient or Responsible Party)

Printed
Name: _____
(Patient or Responsible Party)

Signature:_____

Date: _____

BRUCE P. ROBINSON, MD
PATIENT COVID-19 QUESTIONNAIRE

Name:

Date:

1. **Have you had any COVID-19 symptoms in the past 14 days? (Respiratory illness, new shortness of breath or difficulty breathing, fever, chills. Muscle pain, new cough or runny nose, new sore throat, headaches or new loss of taste or smell, new vomiting or diarrhea)**

Circle one: Yes or No

2. Have you been in contact with anyone who has been ill or tested positive for COVID-19 in the past 14 days?

Circle one: Yes or No

3. Have you traveled outside of NY, NJ, or CT in the past 14 days? If yes, where have you traveled?

Circle one: Yes or No

4. Has anyone in your household traveled outside of NY, NJ, or CT in the past 14 days? If yes, where have you traveled?

Circle one: Yes or No

5. ONLY the patient will be allowed in the office, UNLESS they are a minor, in which case they may be accompanied by ONE parent.

Initial: _____

6. Patients and visitors will be required to wear a face mask/face covering at ALL times while in our building and office.

Initial: _____

Have you had a Covid Vaccine yet?

Moderna/Pfizer: Dose 1 ___ Date: _____
Dose 2 ___ Date: _____

Johnson & Johnson ___ Date: _____