Greece Dermatological Associates

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WELCOME TO GDA

APPOINTMENT HOURS:

MONDAY	8:00AM to 5:00PM	THURSDAY	8:00AM to 5:00PM
TUESDAY	7:30AM to 3:30PM	FRIDAY	8:00AM to 2:00PM
WEDNESDAY	7:30AM to 3:30PM		

INSURANCE: We are providers for all major insurances in the Rochester area including Aetna, Medicare, Blue Choice, MVP, BCBS and others. Please call your insurance company for any questions regarding your health insurance coverage.
Please bring your **insurance card and a photo ID** with you to your appointment.

CANCELLATIONS: If you are unable to keep your scheduled appointment, please call our office to notify us as soon as possible. Failure to notify us within 24 hours of your appointment may result in a **No-Show** fee.

PAYMENT: Cash, personal check or credit cards (Visa, Mastercard, Discover, American Express) are accepted as methods of payment. Payment for your visit is expected on the day of your appointment. There will be a $10.00 additional fee if your copay is not received at the time of service. You are responsible for all cost of health services if your health insurance does not cover the office visit/procedures.

REGISTRATION FORM: Please complete the enclosed information sheet and medical history form and return in the self-addressed envelope prior to your appointment.

REFERRALS: Once you are an established patient, you must check to make sure that you have an authorization for your next appointment, if your insurance company requires one.

Please call our office should you have any questions or visit our website for further information and directions.

Thank you.

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Appointment Date_____ Time_____ Dr._____

Information should be updated yearly, or as needed

Patient Information

Legal Name _____ **Date of Birth** _____-_____-_____
MM DD YYYY

SEX: ☐ ☐ M / F **Maiden name** _____

Address_____
(Street) (City) (State) (Zip)

Cell Phone (_____)_____-_____ **Work Phone** (_____)_____-_____ext._____

Home Phone (_____)_____-_____ **E-mail** _____

Occupation _____ **Employer** _____

Primary Care Dr. _____ **Address** _____ **Phone** (_____)_____-_____

Emergency contact _____ **Relationship** _____ **Phone** (_____)_____-_____

Address_____
(Street) (City) (State) (Zip)

if a minor

Father's Name _____ **Employer** _____ **Phone** (_____)_____-_____

Address_____
(Street) (City) (State) (Zip)

Mother's Name _____ **Employer** _____**Phone** (_____)_____-_____

Address_____
(Street) (City) (State) (Zip)

Insurance Information

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

SUBSCRIBER NAME _____ SUBSCRIBER NAME _____

SUBSCRIBER ID _____ SUBSCRIBER ID _____

My signature verifies that all information listed is true and to the best of my knowledge. I authorize insurance companies to pay provider directly. I understand that I am responsible for any and all charges not covered by insurance. It is understood and agreed that in the event any outstanding balance on my account becomes delinquent and has to be referred to a collection agency or address attorney for recovery, that I will be fully responsible for any and all collection fees and attorney fees.

_____
Signature: Patient / Parent / Guardian / Power of attorney Date

rev 11/17

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Patient History Form

Patient Name_____ **Age**_____ **Primary Care Dr**_____
Cell Phone #_____ **Occupation**_____ **Pharmacy**_____

Reason for Today's Visit?_____

What illnesses do you have (Ex: diabetes, heart disease, ulcers, etc)?_____

_____

List any medications you are taking _____

_____

Medication Allergies_____
Other Allergies (food, animals, mold, grass, etc)_____

What surgical procedures have you had?_____

Have you ever had problems with any of the following:	Yes	No	If yes, please explain:
Eyes	☐	☐	
Ears-Nose-Throat	☐	☐	
Dental	☐	☐	
Heart	☐	☐	
Lungs	☐	☐	
Digestive tract	☐	☐	
Arthritis	☐	☐	
Headaches/Seizures	☐	☐	
Depression/Anxiety	☐	☐	
Diabetes	☐	☐	
Thyroid disease	☐	☐	
High cholesterol	☐	☐	
Kidney Disease	☐	☐	
Liver Disease	☐	☐	
Skin	☐	☐	
Other			

Family History	**YES**
Melanoma	☐
Other Skin Cancer	
Eczema	☐
Lupus	☐
Psoriasis	☐
Other	

Social History	**YES**	**NO**
Alcohol	☐	☐
Smoking	☐	☐
Drugs	☐	☐
Hobbies		

Women: Are you pregnant? YES ☐ **NO** ☐ **Planning to become pregnant? YES** ☐ **NO** ☐

Patient Signature_____ Date_____ rev 11/17

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*Sign and date this acknowledgement form *
*The FULL NOTICE OF PRIVACY PRACTICE is available upon request or online at www.greecedermatology.com *

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

SUMMARY

The confidentiality of your personal health information, commonly called your medical record, has always been a high priority for the nurses, doctors, staff and others involved in your healthcare at Greece Dermatological Associates. There are a number of reasons that we may need to use this information or release (disclose) it to others. This Notice of Privacy Practices is provided to Inform you of the way that we can use and release information from your medical record. THIS PAGE IS NOT THE FULL NOTICE OF PRIVACY PRACTICES, PLEASE READ THE ATTACHED DOCUMENT FOR ADDITONAL INFORMATION. In addition to the longstanding commitment of Greece Dermatological Associates to protecting your information, there are certain obligations that we have under federal law. One of those obligations is to provide you with this Notice.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communication;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

I acknowledge that I have been provided Greece Dermatological Associate's Notice of Privacy Practices:

_____ _____
Patient or Representative Signature Date

___Patient refused to sign

If you would like to allow someone else to have access to your medical information, please list their names below:

I_____(your name) hereby authorize _____ to receive information regarding my medical records.

I_____(your name) hereby authorize _____ to receive information regarding my medical records.