Carin H. Gribetz, M.D., P.C.
108 East 86th Street Suite 1N
New York, New York 10028 Tel 212-289-3300

Name ______________________________ Age________ Date of birth_______
Gender_____Marital Status ______
Address __________________________________________________________________
__________________________________________________________________________
Home (___) _________ May we leave a message at home regarding your care? Yes__No __
Work (___) _________May we leave a message at work regarding your appointments? Yes__No _
Cell (___) __________

Occupation______________ Employer__________ Work Address___________________
Spouse's Name____________________ Phone (___) _____________________

Whom May We Thank For Referring You? ________________________________________

Referring M.D. Address and Phone number_____________________________________
(if applicable)

Primary Care Physician________________Address_______________________________
Phone number_________________________

May we discuss your medical condition with another family member? Yes___No__
If yes, whom ______________________________ Relationship ________________

*In case of emergency ___________________________ Work# _________________
Relationship to patient ____________________ Cell# _________________

If patient is a minor please enter responsible party information.
Name _______________________________ SS# _____________ DOB ____/____/_____
Address ______________________________________________
__________________________________________________________________________
Home (____) _____________Work (____) ______________Cell (____) _________________

Please Note: Patients are responsible for fees at the time of visit.
We Will Assist You In the Proper Processing Of Your Insurance Forms.

I hereby Authorize Carin H. Gribetz, M.D., P.C.:
To release requested information to my insurance company
To consider a photocopy of this registration form as valid as the original
To take and include relevant photographs in my patient record

**Patient/Guardian Signature ____________________________ Date_________**

The information on this form is part of your patient record. It therefore receives the same stringent doctor-patient confidentiality safeguards as the rest of your medical record, including status privileged information and is subject to the federal HIPAA confidentiality safeguards and rules.

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**Initial Visit Questionnaire:**
To help us give you the best possible care, please carefully complete all questions on this form.

How can we can we help you today?________________________________________________

**Have you ever had or been treated for any of the following conditions?**

| | | | | | |
|---|---|---|---|---|---|
| Difficulty with healing of wounds | **Yes** □ | **No** □ | Heart Disease | **Yes** □ | **No** □ |
| Overgrown scars or keloids | **Yes** □ | **No** □ | High Blood Pressure | **Yes** □ | **No** □ |
| Eye disorder(Glaucoma, Cataracts) | **Yes** □ | **No** □ | Duodenal/Peptic Ulcer | **Yes** □ | **No** □ |
| Thrombophlebitis | **Yes** □ | **No** □ | Stroke | **Yes** □ | **No** □ |
| Excessive Bleeding | **Yes** □ | **No** □ | Intestinal disease/colitis | **Yes** □ | **No** □ |
| Arthritis, Joint, Bone Problems | **Yes** □ | **No** □ | Lung Disease | **Yes** □ | **No** □ |
| Cancer | **Yes** □ | **No** □ | Neurological Disorder | **Yes** □ | **No** □ |
| Diabetes or Thyroid Disease | **Yes** □ | **No** □ | Pacemaker | **Yes** □ | **No** □ |
| Kidney, Bladder Disease | **Yes** □ | **No** □ | Venereal Disease | **Yes** □ | **No** □ |
| Blood/Lymph Node Disorder | **Yes** □ | **No** □ | Psychiatric Disease | **Yes** □ | **No** □ |

**Have you or any members of your family (specify who) had:**

| | | | | | |
|---|---|---|---|---|---|
| Asthma | **Yes** □ | **No** □ | Psoriasis | **Yes** □ | **No** □ |
| Seasonal Allergies | **Yes** □ | **No** | Skin Cancer | **Yes** □ | **No** □ |
| Eczema | **Yes** □ | **No** □ | Glaucoma | **Yes** □ | **No** □ |
| Hives | **Yes** □ | **No** □ | Other skin condition | **Yes** □ | **No** □ |

**Have you previously been treated for a skin condition? If yes, please describe**_______________________________________________________________

**Have you ever been given X-ray or Grenz Treatment to your skin?** **Yes** □ **No** □

**Do you Use Sunscreen?** **Yes** □ **No** □ **If so, what SPF?**________________

**Do you take any medications (including prescription medications, over-the-counter drugs, vitamins, herbal supplements, etc.)?**_______________________________________________________________________

**Do you have any allergies, including those to local or dental anesthesia, topical or oral medications?**___________________________________________________________

**Please list prior hospitalizations and surgeries (including dates):** __________________________________

**For Women Only:**
**Are you currently pregnant?** **Yes** □ **No** □
**Are you planning a pregnancy?** **Yes** □ **No** □
**Do you get yeast infections?** **Yes** □ **No** □

**Signature**__________________________________ **Date**____________

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**Notice of Privacy practices**

**Protected health information (PHI)** is information about the patient that includes demographic information and that which relates to his or her past, present, future physical or mental health and related healthcare services.

**Patients' rights in regard to use and disclosure of your health information**

You, the patient, have the right under HIPAA (Health insurance portability and accountability act of 1996) to:

- Inspect and request a copy of your medical record or other PHI, subject to our approval
- Request an amendment in PHI
- Request restrictions on certain PHI uses and disclosures
- Obtain from us an accounting of any PHI disclosures
- Request changes or restrictions in the way our practice communicates protected health information to the patient
- Receive a copy of our practice's privacy policy
- Complain about any alleged violations of the HIPAA privacy rules

***Carin H. Gribetz, M.D****. makes every effort to respect patients' need for privacy and individual dignity.* We treat patients' protected health information (PHI) as confidential and we use and disclose PHI only in conformance with state and federal laws. We abide by the above list of patients' rights over their own PHI.

***Carin H. Gribetz, M.D.*** *uses patients' protected healthcare information for treatment, payment, and healthcare operations*. For these purposes, this practice may share patients' PHI with healthcare providers, health plans, healthcare clearinghouses, and business associates.

Example of use of PHI for treatment: using the results of lab tests for diagnosis
Example of use of PHI for payment: checking with an insurance carrier to make sure that patient is eligible for benefits.
Example of use of PHI for healthcare operations: using PHI to evaluate the quality of care the patient receives.

***Carin H. Gribetz, M.D.*** *does not make certain disclosures of patients' phi without the patients' authorization*: our practice and its physicians and staff will not use or disclose PHI without the patient's authorization for disclosure to such outside entities as employers, insurance companies, drug companies and journalists, and will not use PHI without authorization for marketing, research or fundraising, except under certain limited circumstances. We will adhere to restrictions of PHI use that the patient has requested and the practice has approved.

***Carin H. Gribetz, M.D.*** *requires compliance with these policies.*
More detailed information is available. Our practice manager is available to speak with you during business hours.

______________________________ _________________
Name Date

______________________________
Signature