MANDEL
DERMATOLOGY

PATIENT INFORMATION

FIRST NAME:	MIDDLE NAME:	LAST NAME:
SEX:	DATE OF BIRTH: / /	AGE YRS MO DAYS
STREET:	CITY, ST, ZIP:	CELL #:
EMAIL:	I UNDERSTAND THAT BY PROVIDING MY EMAIL ADDRESS, I CONSENT TO RECEIVING OCCASIONAL EMAILS FROM THE PRACTICE.	
REFERRING DOCTOR:		
PRIMARY CARE PHYSICIAN:		
REASON FOR VISIT:		

DEMOGRAPHIC INFORMATION

RACE: ETHNICITY: □ HISPANIC / LATINO □ NON-HISPANIC / LATINO

PHARMACY INFORMATION

NAME:	ADDRESS/TOWN:	PHONE:

PLEASE ANSWER THE FOLLOWING QUESTIONS

WHAT IS YOUR HEIGHT AND WEIGHT?

HEIGHT:
WEIGHT:

ARE YOU ALLERGIC TO ANY MEDICATION? □ YES □ NO

IF YES, PLEASE LIST:

ARE YOU ALLERGIC TO ANYTHING ELSE? □ YES □ NO

IF YES, PLEASE LIST:

HAVE YOU HAD ANY SURGERIES OR HOSPITALIZATIONS? □ YES □ NO

IF YES, PLEASE LIST:

ARE YOU CURRENTLY TAKING ANY MEDICATIONS (INCL. BIRTH CONTROL) □ YES □ NO

IF YES, PLEASE LIST WITH DIAGNOSIS:

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FOR FEMALE PATIENTS, ARE YOU PREGNANY OR NURSING?	□ YES	□ NO
IF NO, ARE YOU TRYING TO GET PREGNANT:	□ YES	□ NO
DO YOU SMOKE CIGARETTES?	□ YES	□ NO
IF YES, HOW MANY CIGARETTES PER DAY?:		
DO YOU DRINK ALCOHOL?	□ YES	□ NO
IF YES, HOW MANY DRINKS PER DAY?:		

MEDICAL HISTORY

DO YOU HAVE ANY MEDICAL HISTORY (E.G. ASTHMA, DIABETES, HYPERTENSION, ETC.)?

IMMUNIZATION HISTORY

HAVE YOU BEEN VACCINATED FOR THE FOLLOWING? (IF YES, PLEASE CHECK AND LIST MO/YR)

□ FLU - *DATE:* _____ □ COVID-19 - *DATE:* _____ □ PNEUMONIA - *DATE:* _____ □ OTHER (LIST)

FAMILY HISTORY

IS THERE A FAMILY HISTORY OF ANY OF THE FOLLOWING?

□ SKIN CANCER □ MELANOMA □ IRREGULAR MOLES □ ECZEMA □ PSORIASIS □ LUPUS
□ DIABETES □ CANCER (NON-SKIN) – IF SO, PLEASE EXPLAIN □ OTHER – IF SO, PLEASE EXPLAIN

PLEASE EXPLAIN:

SYSTEMIC REVIEW (CURRENT)

ARE YOU CURRENTLY EXPERIENCING ANY PROBLEMS OR SYMPTOMS?

□ CARIOLOGY (HEART / CIRCULATORY) □ ALLERGY □ ENT (EAR / NOSE / THROAT)
□ MUSCULOSKELETAL □ HEMATOLOGIC / LYMPHATIC (BLOOD) □ SKIN □ OTHER – IF SO, PLEASE EXPLAIN

PLEASE EXPLAIN:

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COSMETIC

WHICH OF THE FOLLOWING MAY YOU BE INTERESTED IN?

NEWEST TREATMENTS AVAILABLE (SEE DETAILS BELOW):

□ **TRUSCULPT ID**	□ **ACCUTITE**	□ **MORPHEUS8 MICRONEEDLING**
• **UP TO 24% FAT ELIMINATION** • **15 MINUTE TREATMENT** • TREAT TARGETED AREAS • CELLULITE REDUCTION • SKIN TIGHTENING • PAIN FREE TREATMENT	• NON-SURGICAL BLEPHAROPLASTY (EYELID / EYE BAGS) • NON-SURGICAL SKIN TIGHTENING • NO DOWNTIME • SUPERIOR RESULTS	• **REMODELS AND CONTOURS THE FACE AND BODY** • USES THE LATEST RF FRACTIONAL MICRONEEDLING TECHNOLOGY

OTHER COSMETIC TREATMENTS:

□ BOTOX □ FILLER □ FACIALS □ HYDRAFACIAL □ KYBELLA FOR FAT UNDER NECK OR CHIN

□ PRP FOR HAIR LOSS □ MICRONEEDLING WITH PRP FOR AGING SKIN AND BROWN SPOTS

□ LASER HAIR REMOVAL □ SKIN TIGHTENING AROUND EYES AND MOUTH

□ BODYFX RF FAT REDUCTION. □ ISOLAZ (ACNE) □ CHEMICAL PEELS □ MICRODERMABRASION

□ LASER FOR SPOTS □ LASER RESURFACING □ OTHER – IF SO, PLEASE EXPLAIN

IF OTHER, PLEASE EXPLAIN:

PATIENT NAME / DOB:

VISIT DATE:

□ **I'M NOT INTERESTED IN COSMETIC TREATMENTS**

Mitchell J. Mandel, M.D., P.C. 116 East 68th Street 1C New York NY 10065 & 500 N. Broadway, 166, Jericho, NY 11753

Mitchell J. Mandel, M.D., P.C. & the practice's associates (e.g MDs, PAs, NPs, Aestheticians, and other staff) make efforts to respect patient's need for privacy and individual dignity. We treat patient's protected health information (PHI) as confidential, and we use and disclose PHI only in conformance with state and federal laws. We respect patient's rights over their own PHI. Mitchell J. Mandel, M.D., P.C. & the practice's associates use the patient's PHI for treatment, payment and healthcare operations. For these purposes, this practice may share patient's 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 the patient is eligible for benefits.
Example of use of PHI for healthcare operations: to evaluate the quality of care the patient receives.

Mitchell J. Mandel, M.D., P.C. & the practice's associates do not make certain disclosures of patient's PHI without the patient's authorization. Our practice & the practice's associates 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 on PHI use that the patient has requested and the practice has approved. Mitchell J. Mandel, M.D., P.C. & the practice's associates require compliance with these policies.

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize Mitchell J. Mandel, M.D., P.C. & the practice's associates to apply for benefits on my behalf for covered services rendered by him or his order. I request payment from my insurance company be made directly to Mitchell J. Mandel, M.D., P.C.. I certify that the information I have reported with regard to my insurance coverage is correct. I understand I am responsible for any deductibles or coinsurance applicable. I understand that some procedures may not be covered by my insurance company and that I am responsible for those charges. I understand that if my insurance company changes, it is my responsibility to notify the practice. I understand that if my insurance company requires a referral, it is my responsibility to make sure a valid referral is on file with the practice.

I understand that if I am on Medicaid or a Medicaid HMO or any other Medicaid insurance plan, that the practice and its associates do not accept any type of Medicaid insurance and that I agree to pay for services rendered as a private pay patient. I understand I am being seen as a private pay patient and this is voluntary on my part. I understand I have the option of going to a clinic or facility that will accept my Medicaid plan and I choose not to do so. I understand that some procedures may not be covered by Medicare and that in the event that Medicare does not cover the charges, I will be responsible for those charges and I agree to pay them.

Patient Last Name_____First Name_____MI_____

Signature of patient or legal guardian_____Date_____

Print name of patient or legal guardian_____

Insured's Name_____DOB_____

Spouse Child Parent Other_____