Konstadt and Russo Dermatology PLLC

Jody Konstadt, MD, FAAD
Marian Russo, MD, FAAD

NAME: Last: _____ Middle Initial: _____ First: _____

ADDRESS: _____ APT # _____

CITY: _____STATE: _____ ZIP: _____

HOME #: ( ) _____ - _____WORK#: ( ) _____ - _____ CELL#: _____ - _____

SOCIAL SECURITY #: _____ BIRTHDATE: ____/____/____ AGE: _____

GENDER: Male _____ Female _____

MARITAL STATUS: Single _____ Married_____ Widow _____ Divorced _____ Other _____

EMPLOYER: Name: _____ Address: _____

City: _____ State: _____ Zip: _____ _

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

EMERGENCY CONTACT: Name: _____ Phone #: ( ) _____

PHARMACY INFORMATION: Name: _____ Phone #: ( ) _____

PRIMARY INSURANCE:

Insurance Company: _____

Policy ID: _____Group #: _____

Policy Holder Name: _____

Date of Birth: ____/____/____

SS#_____

For Office Use Only
_____Scanned
$_____ Co pay

SECONDARY INSURANCE:

Insurance Company: _____

Policy ID: _____ Group #: _____

Policy Holder Name: _____

Date of Birth: ____/____/____

SS# _____

IF YOU HAVE NO INSURANCE, PAYMENT IS DUE AT THE TIME OF VISIT.
****A VALID REFERRAL IS REQUIRED AT TIME OF SERVICE****
*****COPAYS ARE DUE AT TIME OF VISIT. *****

I AUTHORIZE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS ANY CLAIMS AND I ALSO AUTHORIZE BENEFITS TO BE PAID DIRECTLY TO JODY KONSTADT MD AND MARIAN RUSSO MD.

Patient's Signature: _____ Date:_____

700 White Plains Rd, Scarsdale, N.Y. 10583 (914) 725-3700

Konstadt and Russo Dermatology PLLC

Jody Konstadt, MD, FAAD
Marian Russo, MD, FAAD

Patient Name: Last: _____ MI: ____ First: _____

Date of Birth: _____/_____/_____

Reason for today's visit:_____

Do you have now, or have you ever had diseases or conditions of:(check yes or no)

Lungs:	**Yes**	**No**	**Other Systemic**	**Yes**	**No**
Bronchitis	☐	☐	Diabetes	☐	☐
Emphysema	☐	☐	Thyroid	☐	☐
Asthma	☐	☐	Kidney	☐	☐
Chronic Cough	☐	☐	Dialysis	☐	☐
Morning Cough	☐	☐	Bladder	☐	☐
Shortness of Breath	☐	☐	Frequency/burning	☐	☐
Wheezing	☐	☐	Gastrointestinal	☐	☐
Cardiovascular:	**Yes**	**No**	Stomach Absorption Disorder	☐	☐
High Blood Pressure	☐	☐	Other_____		
Chest Pain	☐	☐	Arthritis/Joint Deformity	☐	☐
Heart Attack	☐	☐	Arthralgia	☐	☐
Heart Murmur	☐	☐	Limited motion	☐	☐
Irregular Heartbeat	☐	☐	Artificial joint	☐	☐
Phlebitis	☐	☐	Convulsions, Epilepsy or Seizures	☐	☐
Inflammation of vein	☐	☐	Fainting	☐	☐
Blood clots	☐	☐			
Pacemaker	☐	☐			

List all medications you are currently taking and reason:

Medication	Reason for taking	Medication	Reason for taking
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Are you allergic to any medications? ☐Yes ☐No If yes, list below

1._____ 2._____

List any other diseases or conditions:_____

List surgical procedures you have had in the last 6 months: _____

Skin: Have you ever had skin cancer? ☐Yes ☐No

What kind? _____Where? _____Date_____

Has anyone is your family had skin cancer? ☐Yes ☐No

Do you have a history of any specific skin diseases? ☐Yes ☐No

If yes, _____

Do you have problems with healing? ☐Yes ☐No

Do you easily develop scars after surgery? ☐Yes ☐No

Do you bleed easily? ☐Yes ☐No

Social History:

Do you drink alcohol? ☐Yes ☐No If Yes, # of drinks per day _____

Do you smoke? ☐Yes ☐No If Yes, how much: _____

Woman

Are you pregnant? ☐Yes ☐No Due Date: _____/_____/_____

_**x**_____ Date: _____/_____/_____

Patient Signature

Konstadt and Russo Dermatology, PLLC

700 White Plains Road
Scarsdale, NY 10583
(914) 725-3700

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, _____, have reviewed/received a copy of Konstadt and Russo Dermatology PLLC's Notice of Privacy Practices.

_**x**_____ Date: _____/_____/_____
Patient Signature

Protected Health Information (PHI)

Unless I specifically notify you in writing, you shall have the right to contact me via any means of communication I have provided you with.

I understand that I have the right to request confidential communication in writing.

I agree to have information and mailings sent to my home.

I acknowledge if I have questions, concerns, and or complaints I can contact the office.

My Preferences for contact by Konstadt & Russo, Dermatology, PLLC are indicated below: (Please check **all** that apply)

- ☐ Call me at home
- ☐ Leave a message on my answering machine
- ☐ Leave a message with spouse/family member

  Whom:_____

  Relationship:_____

  Their Phone # if different: (_____)_____
- ☐ Call my cell phone
- ☐ Call me at work

_**x**_____ Date: _____/_____/_____
Patient Signature