Dr. Michael Kurzman

Today's Date _____

Patients Name _____ _____
Last *First* *M.I.* *Marital status*

Address _____
City *State* *Zip*

Home # _____ Cell # _____ Work # _____

Date of Birth _____ Sex _____ SSN _____
Email _____

INSURANCE INFORMATION *(Please present Insurance card at the time of check-in)*

Primary Insurance Name _____

ID # _____

Group # _____ Cat # _____

Name of Insured _____

Date of Birth of Insured _____

Relationship of patient to the Insured _____

Employer Name _____

Employer Phone _____

Secondary Insurance Name _____

ID # _____

Group # _____ Cat # _____

Name of Insured _____

Date of Birth of Insured _____

Relationship of patient to the Insured _____

Employer Name _____

Employer Phone _____

- Person responsible for bill _____
- In case of Emergency, Who should be notified? _____ Phone #_____
- Do we have permission to:
  Leave a message on your answering machine? *(if yes, check one)* ❑Home ❑Cell ❑Work
  Discuss your medical condition with any member of your household? ❑Yes ❑No
  If yes, whom? _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims and prescriptions. I also authorize payment of medical benefits to Dr. Kurzman.
Patient Signature _____ Date _____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial policies of this office. Payment is required for all services at the time they are rendered unless you are a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. In the event that your account must be turned over to collections, a $10.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.
Patient Signature _____ Date _____

Please answer the following questions so we can comply with Medicare and Commercial Insurances at our practice. Thank You

Patient name: _____ Date of Birth: _____ Today's Date: _____

Who is your Primary Care Physician? _____ *Month/Year of last visit:* _____

Do you suffer from any of the following? *(check off those that apply)*

- ❑ Heart Failure
- ❑ Coronary Artery Disease (CAD)
- ❑ Chronic Obstructive Pulmonary Disease (COPD)
- ❑ Diabetes

Did you previously receive a Flu shot for this most recent Flu season or are you planning on receiving one?

- ❑ Yes
- ❑ No

Smoking Use:

- ❑ Non Smoker
- ❑ Former Smoker
- ❑ Current Smoker – *How often?* _____

Alcohol Use:

- ❑ None
- ❑ Less than 1 drink per day
- ❑ 1-2 drinks per day
- ❑ 3 or more drinks per day

Do you use IV drugs?

- ❑ Yes
- ❑ No

Patients 65 and older: Have you ever received the pneumonia vaccine?

- ❑ Yes
- ❑ No

Please list ALL allergies to medications

_____

_____

List ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary supplements

_____

_____

Past Medical History: (circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation (irregular Heartbeat)
BPH (enlarged prostate)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension (high blood pressure)
HIV / AIDS
Hypercholesterolemia (high cholesterol)
Hyperthyroidism (overactive)
Hypothyroidism (underactive)
Leukemia
Lung Cancer
Lymphoma
Pacemaker/Defibrillator
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Thyroid

Other Important Medical History: _____

_____

Past Surgical History: (circle all that apply and note approximate date/year of surgery and other key details) None

Appendix _____
Bladder _____
Breast _____
Colon _____
Gallbladder _____
Heart _____
**Transplant*
**Valve replacement*
**Stent*
**Other*: _____
Joint _____
**Which joint?* _____
Kidney _____
Ovaries _____
Prostate _____
Skin _____
Spleen _____
Testicles _____
Uterus _____

Other Surgeries: _____

Personal Skin Disease History: (circle all that apply)

None
Acne
Actinic Keratosis (pre-cancer)
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer

Other Important Skin Disease History: _____

Do you wear Sunscreen? Yes ❑ No ❑ *What SPF?* _____

Do you tan in a tanning salon? Yes ❑ No ❑

Family Skin Disease History: Do you have a family history of skin cancer? Yes ❑ No ❑

**If yes, which relative(s)?* _____

Which type? Squamous cell carcinoma, Basal cell carcinoma, Melanoma

Family History: (please circle all that apply and note which relative)

Arthritis _____
Breast Cancer _____
Cholesterol _____
Colon Cancer _____
Depression _____
Diabetes _____
Heart Disease _____
High Blood Pressure _____
Thyroid disease _____

Other Significant Family History: _____

Primary Local Pharmacy (name, city, zip and phone)

_____

Mail Order Pharmacy (name) _____

Are you currently experiencing any of the following?: (circle all that apply)

Changing mole
Rash
Problems with scarring *(hypertrophic or keloid)* Problems with healing
Problems with bleeding
Yeast infections with antibiotics
GI upset with antibiotics
Pregnancy or planning pregnancy
Thyroid problems
Hepatitis
HIV/AIDS
Abdominal pain
Anxiety
Bloody stool
Bloody urine
Blurry vision
Chest pain
Cough
Depression
Fever or chills
Headaches
Hay fever
Immunosuppression
Joint aches
Muscle weakness
Neck stiffness
Night sweats
Seizures
Shortness of breath
Sore throat
Unintentional weight loss
Wheezing

Other: _____

What is your occupation? _____

Alerts: (circle all that apply)

Allergy to adhesive
Allergy to latex
Allergy to lidocaine
Allergy to medication
Allergy to topical antibiotic ointments
Artificial heart valve
Artificial joints in the last two years
Blood thinners
Defibrillator
MRSA
Pacemaker
Personal history of atypical moles
Personal history of dysplastic nevi
Personal history of Melanoma
Premedication prior to procedures
Rapid heartbeat with epinephrine

Michael Kurzman, M.D.

401 Bloomingdale Rd

Staten Island, NY 10309

Receipt of Notice Privacy Practices

Written Acknowledgement Form.

I _____; have read a copy of Dr. M. Kurzman's notice of Privacy practices.

_____ _____

Signature of Patient Date

MICHAEL
KURZMAN, MD
General & Cosmetic Dermatology

COSMETIC SURGERY INFORMATION: CONSULTATION FORM

Name: _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Home Phone Number: ( ) _____
Cell Phone Number: ( ) _____
E-Mail Address: _____
Best time to call: _____

I am interested in treating the following:

__ Acne
__ Forehead wrinkles
__ Wrinkles between the eyes
__ Skin discoloration
__ Facial wrinkles
__ Anti-Aging
__ Mole Removal
__Laser Hair Removal
__ Acne scars
__ Crow's feet
__ Large pores
__ Thin lips
__ Sagging facial skin
__ Skin Screening
__ Psoriasis Pharos Excimer__
__ Other (Please explain below)

Additional Questions:

_____

_____

_____