# DAVID ROSENBERG, M.D., PLLC

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## Welcome
## Please fill out this form completely

**Mail to: 115 East 61st Street , New York, NY 10065**
**-or-**
**Fax to: 212-421-0176**

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NAME ______________________________________________________
Last First Mrs Mr Ms Dr

AGE______ DATE OF BIRTH___________ SEX______ SOC. SEC. #_____________

HOME ADDRESS: ______________________________________________________
Street (Apt#)

______________________________________________________
City State Zip

HOME PHONE (_____) _________________WORK PHONE (_____) ______________
MOBILE PHONE (_____) _______________ OTHER PHONE (_____) _____________
EMAIL: ________________________________________________________________

EMPLOYER _____________________________________________
WORK
ADDRESS______________________________________________________________
Street City State Zip
EMERGENCY
CONTACT____________________________PHONE_____________________________
IF UNDER 18 YEARS OLD:
PARENT NAME_________________________________________

**Name of Internist:** ___________________ **Telephone #:** ________________
**Name of Cardiologist:** _______________ **Name of Dermatologist:** _____________

**Cosmetic surgery is not covered by insurance. For reconstructive surgery, it is your responsibility to submit claims to your insurance company. We are happy to provide an itemized bill after surgery.**

I request payment of authorized insurance carrier benefits be made on my behalf to David Rosenberg, MD, PLLC for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. Furthermore, it is my understanding that, regardless of insurance coverage, payment for services rendered is my responsibility.

**SIGNATURE**_____________________________________________**DATE**_________

# Health Questionnaire

**Name: ________________________________ Date: _______________**

**Reason for today's visit: _______________________________________________**

**1. Have you ever suffered from?**

| | Yes | No |
|---|---|---|
| Heart Disease | ___ | ___ |
| High Blood Pressure | ___ | ___ |
| Heart Attack | ___ | ___ |
| Emphysema | ___ | ___ |
| Asthma | ___ | ___ |
| Blood Disease | ___ | ___ |
| Kidney Disease | ___ | ___ |
| Glaucoma | ___ | ___ |
| Diabetes | ___ | ___ |
| Jaundice/Hepatitis | ___ | ___ |
| Cancer | ___ | ___ |
| Anemia | ___ | ___ |
| Easy Bruising | ___ | ___ |
| Facial Trauma | ___ | ___ |
| Dry Eyes | ___ | ___ |
| Eating Disorder | ___ | ___ |

Elaborate as needed:_________________
_________________________________
_________________________________

**2. Do You take?**

| | Yes | No |
|---|---|---|
| St. John's Wort | ___ | ___ |
| Aspirin | ___ | ___ |
| Ginko | ___ | ___ |
| Vitamin E | ___ | ___ |

**3. Have you ever taken?**

| | Yes | No |
|---|---|---|
| Fen Fen | ___ | ___ |
| Accutaine | ___ | ___ |

When? ___________________________

**4. What medications do you use?**
_________________________________
_________________________________
_________________________________

**5. What medication are you allergic to?**
_________________________________

**6. Do you have any other medical problems?**__________________
______________________________
______________________________

**7. Have you been hospitalized**?
**Yes___ No___ Please describe:**
______________________________
______________________________

**8. Have you ever had cosmetic surgery? Yes___ No___ Please describe:**___________________
______________________________
______________________________

**9. Have you ever had any other surgery? Please describe:**_____
______________________________
______________________________

**10. Have you ever had any of the following habits?**

| | **Yes** | **No** |
|---|---|---|
| Smoking | ___ | ___ |
| Frequency______________ | | |
| Alcohol | ___ | ___ |
| Frequency______________ | | |
| Recreational Drugs | ___ | ___ |
| Frequency______________ | | |

**11. Do you have any caps, crowns, bridges or loose teeth?**_________
______________________________

**12. Are you currently undergoing dental work?**__________________
______________________________

**13. How did you hear of our office?**________________________
______________________________
______________________________
______________________________
______________________________

**DAVID ROSENBERG, M.D., PLLC**

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for The Office of Dr. David Rosenberg to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Healthcare Operations (TPO). (The Office of Dr. David Rosenberg's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Office of Dr. David Rosenberg reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Office of Dr. David Rosenberg at 115 E. 61st Street, New York, NY 10065.

With this consent, the Office of Dr. David Rosenberg may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, The Office of Dr. David Rosenberg may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, The Office of Dr. David Rosenberg may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that The Office of Dr. David Rosenberg restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the Office of Dr. David Rosenberg's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it; the Office of Dr. David Rosenberg may decline to provide treatment to me.

______________________________

Signature of Patient or Legal Guardian        Date: ____________________________

______________________________

Print Patient's Name