

WELCOME TO THE OFFICE OF DRs. MARC & DAVID AVRAM. PLEASE TELL US ABOUT YOURSELF:

Last Name: _____ First Name: _____ Gender: _____

Address: _____ Apt. #: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Cell/Alternate Phone: _____

Email: _____ Please check where we can leave you a message if necessary:

Social Security #: _____ Emergency Contact Name & #: _____

Date of Birth: _____ Your Employer: _____ Your Occupation: _____

Do you need prophylaxis? _____ Name of guardian, if patient is a minor: _____

Reason for being seen today: _____

How did you hear about us? _____

Please list all **medications** you are presently taking:

Please list all **allergies** (medication or otherwise):

Do you have a history of:					
	Self	Family		Self	Family
Asthma			Bleeding Problems		
Heart Problems			Diabetes		
Eye Trouble			Stomach Ulcers		
Hypertension			Hepatitis		
Tuberculosis			Kidney Disease		
Tendency to scar tissue			Pacemaker		
History of skin cancer			Other Illnesses		

If you have answered "yes" to any of these questions, please describe in detail: _____

Have you ever received a blood transfusion? _____ When? _____

Is it possible you are pregnant? _____ Are you breast feeding? _____

For Medicare patients:
 I hereby authorize payment of medical benefits to Drs. Marc and David Avram.

Signature: _____ Date: _____

All other patients:
 I hereby give permission to bill my insurance company. I realize I am financially responsible for any unpaid balance. I understand my insurance company may not pay for cosmetic procedures, therefore I realize I am responsible for payment in full.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of this Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please print your name here

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

The patient refused to sign.

Due to an emergency situation it was not possible to obtain acknowledgement.

We weren't able to communicate with the patient.

Other (Please provide specific details.) _____

Employee Signature

Date