Israel S. Eckman, M.D., PLLC

165 North Village Ave, Suite 129
Rockville Center, NY 11570

Patient Information

_____ _____ _____ **Sex: ☐ M ☐ F**
Last Name **First Name** **Middle Initial**

_____
Full Address **Apt #** **City** **State** **Zip**

_____/_____/_____ _____ **Marital Status (Circle): S M D W**
Date of Birth **Social Security Number**

(_____) _____ **(_____) _____**
Best Contact Number (Circle) Home/Work/Mobile **Alternate Contact Number (Circle) Home/Work/Mobile**

_____ _____
E-Mail Address **Race**

Primary Insurance Coverage

_____
Insurance Company

_____
Name Insured

_____ _____
Relationship to Policy Holder **Policy Holder Date of Birth**

_____
Policy Number/Subscriber Number

_____ _____
Group Number **Specialist Co-Pay Amount**

_____
Insurance Billing Address (Back of Card)

_____
Insurance Billing Address Line 2

Secondary Insurance Coverage

_____
Insurance Company

_____
Name Insured

_____ _____
Relationship to Policy Holder **Policy Holder Date of Birth**

_____
Policy Number/Subscriber Number

_____ _____
Group Number **Specialist Co-Pay Amount**

_____
Insurance Billing Address (Back of Card)

_____
Insurance Billing Address Line 2

Patient's Authorization

I authorize Israel S. Eckman, M.D., LLC to apply for benefits on my behalf for services rendered by Israel S. Eckman, M.D., LLC. I request payment from my insurance company be made directly to Israel S. Eckman, M.D., LLC. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

_____ _____
Signature of Subscriber of Beneficiary Date

Please check any medical conditions:

- ❒ Anxiety
- ❒ Arthritis
- ❒ Asthma
- ❒ Atrial Fibrillation
- ❒ Bone Marrow Transplant
- ❒ Colon Cancer
- ❒ COPD
- ❒ Coronary Artery Disease
- ❒ Depression
- ❒ Breast Cancer
- ❒ Diabetes
- ❒ BPH
- ❒ End Stage Renal Disease
- ❒ GERD
- ❒ Hearing Loss
- ❒ Hepatitis
- ❒ High Blood Pressure
- ❒ HIV/AIDS
- ❒ High Cholesterol
- ❒ Hyperthyroid (overactive)
- ❒ Hypothyroid (underactive)
- ❒ Leukemia
- ❒ Lung Cancer
- ❒ Lymphoma
- ❒ Pacemaker
- ❒ Prostate Cancer
- ❒ Radiation Treatment
- ❒ Seizures
- ❒ Stroke
- ❒ NONE
- ❒ Other_____

Please check any skin conditions:

- ❒ Acne
- ❒ Actinic Keratoses
- ❒ Basal Cell Skin Cancer
- ❒ Blistering Sunburns
- ❒ Dry Skin
- ❒ Eczema
- ❒ Flaking/Itchy Scalp
- ❒ Hay Fever/Allergies
- ❒ Melanoma
- ❒ Poison Ivy
- ❒ Precancerous Moles
- ❒ Psoriasis
- ❒ Squamous Cell Skin Cancer
- ❒ Other_____
- ❒ Family History of Non Melanoma Skin Cancer
- ❒ Family History of Melanoma
- ❒ NONE

Social History:

Do you smoke?

- ❒ Current Smoker
- ❒ Former Smoker
- ❒ Never Smoker

Do you drink alcohol?

- ❒ Never
- ❒ Less than 1 per day
- ❒ 1-2 per day
- ❒ 3 or more per day

How often do you exercise:

- ❒ Never
- ❒ A few times a month
- ❒ A few times a week
- ❒ Once a day

Do you drink caffeine?

- ❒ Never
- ❒ A few times a month
- ❒ A few times a week
- ❒ Once a day
- ❒ Several times a day

What is your occupation?

_____

Please list any medications you are currently taking:

_____
_____
_____
_____
_____

Please list any drug allergies:

_____
_____
_____

Please list any major surgeries & dates:

_____
_____
_____
_____

Please list any procedures done in the last 6 months:

_____

Please check if you have any of the following:

- ❒ Rash
- ❒ Problems with Scarring
- ❒ Problems with Healing
- ❒ Problems with Bleeding
- ❒ Immunosuppression
- ❒ Chest Pain
- ❒ Fever or Chills
- ❒ Night Sweats
- ❒ Unintentional Weight Loss
- ❒ Sore Throat
- ❒ Joint Aches
- ❒ Muscle Weakness
- ❒ Neck Stiffness
- ❒ Abdominal Pain
- ❒ Headaches
- ❒ Shortness of Breath
- ❒ Sore Throat
- ❒ Cough
- ❒ Blurry Vision
- ❒ Wheezi