



Department of Dermatology  
5 East 98<sup>th</sup> Street – 5<sup>th</sup> Floor  
New York, NY 10029-6574  
Tel 212.241.9728  
Fax 212.241.1197

Welcome!

Thank you for choosing **Mount Sinai Dermatology Associates** for your care. Enclosed is our Mission Statement and a list of our faculty.

In an effort to expedite the check-in process, all new patients will have the opportunity to complete the attached registration packet prior to their office visit.

Please remember to bring your insurance card to your appointment. If your insurance plan has a co-payment for office visits, that fee will be requested at the time of service.

If you have any questions, do not hesitate to contact our office and be sure to indicate that you are calling about your registration. Our number is 212.241.9728. (Option# 1)

We look forward to seeing you!

The Faculty and Staff  
Department of Dermatology  
The Mount Sinai Medical Center

**This e-mail is not operational for messages. Please do not use it to contact the Department**

# MOUNT SINAI DERMATOLOGY ASSOCIATES - PATIENT INFORMATION

Date \_\_\_\_\_  New  Update

Name \_\_\_\_\_  
First Middle Initial Last

Name of parent or guardian (if applicable) \_\_\_\_\_

Address \_\_\_\_\_  
Street No. Apt. No. City/Town State Zip Code

Tel Nos. Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_ Ext. \_\_\_\_\_  
Area Code Area Code Area Code

E-mail \_\_\_\_\_

Preferred Mode of Contact ( ) Cell ( ) E-mail ( ) Home Phone ( ) Work Phone

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Mo/Day/Year

Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_ Your gender ( ) M ( ) F

Preferred Language \_\_\_\_\_ Race \_\_\_\_\_

Ethnicity Check One ( ) Hispanic or Latino or Spanish Origin ( ) Not Hispanic or Latino or Spanish Origin

Occupation \_\_\_\_\_

Name of Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_  
Street City/Town State Zip Code

Name of Referring Physician \_\_\_\_\_ Tel No. \_\_\_\_\_

Physician's Address \_\_\_\_\_  
Street City Zip Code

\* Person to Contact in: \_\_\_\_\_ \*

|                   |      |                         |              |
|-------------------|------|-------------------------|--------------|
| Case of Emergency | Name | Tel. No. with Area Code | Relationship |
|-------------------|------|-------------------------|--------------|

## Insurance Information

*Please have insurance identification card(s) available for office staff.*

### PRIMARY INSURANCE

Insurance Company \_\_\_\_\_  
Claims Mailing Address \_\_\_\_\_  
Tel No. \_\_\_\_\_  
ID No. \_\_\_\_\_ Group Number \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Insured's Birth Date \_\_\_\_\_ Insured's Employer \_\_\_\_\_  
Address \_\_\_\_\_  
Tel. No. \_\_\_\_\_

### SECONDARY INSURANCE

Insurance Company \_\_\_\_\_  
Claims Mailing Address \_\_\_\_\_  
Tel No. \_\_\_\_\_  
ID No. \_\_\_\_\_ Group Number \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Insured's Birth Date \_\_\_\_\_ Insured's Employer \_\_\_\_\_  
Address \_\_\_\_\_  
Tel. No. \_\_\_\_\_



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## Pharmacy Information

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Telephone Numbers \_\_\_\_\_  
Preferred Telephone No. \_\_\_\_\_ Home \_\_\_\_\_

*Please list pharmacies in order of preference:*

### Primary Pharmacy

Pharmacy Name \_\_\_\_\_  
Address \_\_\_\_\_  
Street City State Zip Code  
Telephone Number(s) \_\_\_\_\_  
Fax Number \_\_\_\_\_

### Secondary Pharmacy

Pharmacy Name \_\_\_\_\_  
Address \_\_\_\_\_  
Street City State Zip Code  
Telephone Number(s) \_\_\_\_\_  
Fax Number \_\_\_\_\_

## PATIENT HEALTH HISTORY

To help us give you the best possible care, please carefully complete all questions on this form. If you do not know the answer to a particular question, leave it blank. Thank you.

Patient's name \_\_\_\_\_

### 1. Have you ever had or been treated for any of the following?

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Duodenal or peptic ulcer .....                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other intestinal disease                         |                              |                             |
| or colitis                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Liver or gall bladder disease                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lung disease (TB, pleurisy, etc.)                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart disease (rheumatic fever, pacemaker, etc.) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High blood pressure                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stroke   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney disease                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Urinary or bladder problem or infection          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Venereal disease                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood or lymph gland disorder                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Eye disease (cataract, cataract surgery)         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis, joint problems or bone disease        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Thrombophlebitis                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Frequent infections of the skin or other areas   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Neurological disorder                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Emotional or psychiatric problem                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

### 2. Have you or any members of your family had any of the following? Please specify whom.

- |                                 |                              |                             |                               |                                |       |
|---------------------------------|------------------------------|-----------------------------|-------------------------------|--------------------------------|-------|
| Asthma .....                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Self | <input type="checkbox"/> Other | _____ |
| Hay fever                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Self | <input type="checkbox"/> Other | _____ |
| Eczema                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Self | <input type="checkbox"/> Other | _____ |
| Hives                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Self | <input type="checkbox"/> Other | _____ |
| Diabetes                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Self | <input type="checkbox"/> Other | _____ |
| Psoriasis                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Self | <input type="checkbox"/> Other | _____ |
| Skin cancer                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Self | <input type="checkbox"/> Other | _____ |
| Glaucoma                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Self | <input type="checkbox"/> Other | _____ |
| Other skin conditions (specify) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Self | <input type="checkbox"/> Other | _____ |

### 3. Have you or any members of your family had any of the following? Please specify whom.

- |                                       |                              |                             |                               |                                |       |
|---------------------------------------|------------------------------|-----------------------------|-------------------------------|--------------------------------|-------|
| Excessive bleeding when cut           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Self | <input type="checkbox"/> Other | _____ |
| Difficulty with the healing of wounds | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Self | <input type="checkbox"/> Other | _____ |
| Overgrown scars or keloids            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Self | <input type="checkbox"/> Other | _____ |
| Allergy to local anesthetics          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Self | <input type="checkbox"/> Other | _____ |

### 4. Have you previously had a skin problem or been under the care of a dermatologist? If yes, please describe.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**5. Social History**

Have you ever had a venereal disease?  Yes  No  
 Do you smoke?  Yes  No  
 If yes, how many cigarettes or packs per week? (Specify which) \_\_\_\_\_  
 Do you drink alcohol?  Yes  No  
 If yes, how many drinks do you consume on a weekly basis? \_\_\_\_\_  
 Are you married  single  other ? If other, please elaborate \_\_\_\_\_

6. Have you ever been given X-ray or Grenz treatments for your skin?  Yes  No

7. Do you take any medicine, drugs or over-the-counter preparations or remedies?  Yes  No  
 (These might include medicines for sleep, constipation, headaches, birth control or "nerves.")

8. Are you allergic to any medicines, drugs or over-the-counter preparations or remedies?  Yes  No

9. Please provide details of any prior hospitalizations or surgeries:

| Reason for Hospitalization/Surgery | Dates of Hospitalization/Surgery | Outcome |
|------------------------------------|----------------------------------|---------|
|                                    |                                  |         |
|                                    |                                  |         |
|                                    |                                  |         |
|                                    |                                  |         |
|                                    |                                  |         |
|                                    |                                  |         |

**10. For Women Only**

Have you ever had vaginal yeast infections? .....  Yes  No  
 Are you pregnant? .....  Yes  No  
 Are you currently planning a pregnancy? .....  Yes  No  
 Are you nursing? .....  Yes  No

**NOTE** The dermatologic examination which you are about to receive is **NOT** a complete physical exam. Therefore, we suggest you have a complete physical examination periodically by your family physician or internist.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Comments \_\_\_\_\_  
 \_\_\_\_\_

Reviewed: 04.07.11 \_\_\_\_\_ Date \_\_\_\_\_  
 Physician's Signature

## MOUNT SINAI USE of INFORMATION AUTHORIZATION

Dear Patient,

Like other major academic medical centers, Mount Sinai depends greatly upon the generosity of our patients to help us provide the finest patient care, to educate the next generation of physicians, and to promote research leading to new treatments and cures.

Federal law now requires health care providers to obtain your written authorization prior to contacting you with marketing information or about philanthropic initiatives that support the work of your physician(s). Your permission for disclosure of your name will allow Mount Sinai staff to contact you about marketing or philanthropic efforts that may be of interest to you.

**No other information about you or your medical treatment will be disclosed—that is strictly between you and your treating physician(s).** Maintaining patient confidentiality and ensuring your right to privacy has always been and will always be a priority at Mount Sinai.

We hope you will take a moment to read this authorization and sign below. If you have any questions, please call the Mount Sinai Development Office at 212.659.8500.

Thank you.

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*I authorize any doctor employed by or on the staff of The Mount Sinai Hospital and The Mount Sinai School of Medicine ("Mount Sinai") to disclose my name and contact information to Mount Sinai Development and Public Affairs staff for the purpose of contacting me about Mount Sinai marketing and philanthropic opportunities. I understand that my health care treatment at Mount Sinai will not be affected in any way by my refusal or failure to sign this form. I further understand that this authorized information will not be released to any third parties for any purpose other than that expressed above. This authorization will remain in effect for five years. However, I may revoke this authorization at any time by writing to the Mount Sinai Development Office at One Gustave L. Levy Place, Box 1049, New York, NY 10029-6574. By signing below, I acknowledge that I have read and accept all of the above.*

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**Signature of the Patient**

**Please PRINT Your Name**

**Date**

---

**Address of Patient**

*If applicable, description of Authority of Personal Representative/Guardian.*

*A signed copy of this form is available upon request by the patient or patient's representative.*

**Mount Sinai Dermatology Associates**  
5 East 98<sup>th</sup> Street – 5<sup>th</sup> Floor  
New York, NY 10029-6574

**FINANCIAL POLICY**

Mount Sinai Dermatology is dedicated to providing our patients with the best possible care and services while keeping the costs to you from increasing at an unreasonable rate. You can play an important role in achieving these objectives by adhering to our financial policy.

**Insurances**

We participate in several health insurance plans. Please check with our BILLING STAFF to determine whether your physician participates in your plan.

If we DO participate, all services performed in our office and in the Mount Sinai Hospital will be submitted to your carrier unless we have received prior notification of non-covered services. All co-pays and deductibles are your responsibility and you will be billed for these.

HMO insurance may require physician referral in order to be covered for a service or services. It is your responsibility as the patient to obtain this referral *prior to* the time of service. If a referral is NOT presented at the time of service, you will be responsible for payment in full for those services on the day of your visit. Every HMO patient is responsible for ALL co-payments at the time of service.

If we DO NOT participate in your health insurance plan, we will not bill your carrier, and we will not accept payment from that carrier as payment in full for the services performed. All insurance carriers have a schedule of fees which determines what they will pay. However, your physician's fees may *be more than* what the carrier allows on its schedule. Therefore, any balance not covered by the insurance carrier is your responsibility. Payment for office visits is due at the TIME OF SERVICE. We will provide you with an itemized bill so you may submit the charges for reimbursement.

**IT IS ESSENTIAL THAT YOU UNDERSTAND YOUR HEALTH COVERAGE IS AN AGREEMENT BETWEEN YOU AND YOUR CARRIER.**

**YOUR PHYSICIAN'S BILL FOR SERVICES PROVIDED TO YOU IS AN AGREEMENT BETWEEN YOU AND YOUR DOCTOR.**

**Payment for Services Performed**

Our office accepts VISA, MasterCard, and AMEX as well as personal checks or cash for your convenience. All required payments as outlined above are expected at the time of service. Any outstanding balances are due within 30 days unless you have made prior arrangements with our BILLING STAFF. All payments that reach 90 days will be sent to our collection agency. In the event this happens, you will be responsible for all collection and legal fees incurred by our office in the attempt to collect your delinquent balance.

Payment in full of any past due balance is expected prior to being seen for another service. In addition, payment in full will be expected at the time of service for any services to be provided at that time. In order for Mount Sinai Dermatology to provide the quality of care we offer, you must be willing to do your part in helping us help you receive insurance benefits for which you may be entitled.

I have read and fully understand the financial policy set for by MOUNT SINAI DERMATOLOGY, and I agree to the terms of this financial policy. I also understand and agree that the terms of the financial policy may be amended by Mount Sinai Dermatology Associates at any time without prior notification to you.

\_\_\_\_\_  
Signature of the Patient and/or Patient's Guardian (SEAL)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please PRINT Your Name



**MOUNT SINAI  
SCHOOL OF  
MEDICINE**



**North Shore  
Medical Group**



**The Mount Sinai  
Hospital  
of Queens**

A Division of The Mount Sinai Hospital



## **CONSENT for COMMUNICATION via E-MAIL (Provider-Patient)**

I, \_\_\_\_\_, hereby consent to have  
Please print  
my physician, \_\_\_\_\_, communicate with me or  
members of his staff, where appropriate or other physicians, nurse practitioners and  
pharmacists via e-mailing regarding the following aspects of my medical care and  
treatment: [test results, prescriptions, appointments, billing, etc.]. I understand that e-  
mail is not a confidential method of communication. I further understand that there is a  
risk that e-mail communications between my physician and me or members of my  
physician's office staff, or between my physician and other physicians, nurse  
practitioners and pharmacists regarding my medical care and treatment may be  
intercepted by third parties or transmitted to unintended parties. I also understand that  
any e-mail communications between my physician and me or members of his office staff,  
or between my physician and other physicians, nurse practitioners or pharmacists  
regarding my medical care and treatment will be printed out and made a part of my  
medical record. I understand that in an urgent or emergent situation I should call my  
provider or go to the Emergency Room and not rely on e-mail.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Mount Sinai Dermatology Associates  
5 East 98<sup>th</sup> Street – 5<sup>th</sup> Floor  
New York, NY 10029-6574**

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**Claims Authorization for MEDICARE and EMPIRE BLUE CROSS/BLUE SHIELD  
Patients or Other Health Insurance**

**ALL PRIVATE PATIENTS**

I understand I am individually responsible for the full payment of the fee(s) for service for all medical services provided by this office. Furthermore, I understand all medical care provided to me or my child/ren is on a fee-for-service basis. Finally, I acknowledge that I have been fully informed of the fees for service provided by this office prior to my care.

**BLUE SHIELD PLAN or OTHER HEALTH INSURANCE**

I hereby authorize any physician, health care practitioner, hospital, clinic or other medical or medically-related facility to furnish any and all records, medical history, services rendered or treatment given to me or any dependent for purposes of review, investigation, or evaluation of any claim submitted to Empire BlueCross and BlueShield or other insurer. I also authorize Empire BlueCross and BlueShield or other insurer to disclose to a hospital or health care service plan, self-insurer, or any insurer, any medical information obtained if such disclosure is necessary to allow the processing of any claim.

If my coverage is under a Group Contract held by an employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with Empire BlueCross and BlueShield or other insurer including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon me, my dependents, and our heirs, executors and administrators.

**MEDICARE**

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to this office for any services furnished by my examining 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 the related services.

**AUTHORIZATION TO PAY**

I request payment of this claim and, if the payor accepts assignment, authorize payment directly to the physician and supplier for the services as described.

PATIENT (or AUTHORIZED INDIVIDUAL) NAME \_\_\_\_\_  
PRINT Name

PATIENT (or AUTHORIZED INDIVIDUAL) NAME \_\_\_\_\_ Date \_\_\_\_\_  
Signature



North Shore  
Medical Group



The Mount Sinai  
Hospital  
of Queens

A Division of The Mount Sinai Hospital



Diagnostic  
and  
Treatment  
Center

## SUMMARY - NOTICE OF PRIVACY PRACTICES

**THIS IS A SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. WE HAVE ALSO MADE AVAILABLE TO YOU A FULL VERSION OF THE NOTICE.**

### **Our Pledge to Protect your Privacy:**

The Mount Sinai Hospital, Mount Sinai School of Medicine and Mount Sinai Diagnostic and Treatment Center ("Mount Sinai") are committed to protecting the privacy of your medical information. So that we can best meet your needs, we share your medical information with all the healthcare providers involved in your care. Only to the extent necessary, we also use and share your information to conduct our business operation, to collect payment for the services we provide to you and to comply with the laws that govern healthcare. We will not use or disclose your information for any other purpose without your permission.

### **You have the following rights to access and control your health information: (See Notice pp. 3-6 )**

- To inspect and obtain a copy of your medical and billing records, subject to some special requirements for substance and alcohol abuse, genetic, mental health and HIV-related data;
- To request restrictions on certain uses or disclosures of your medical information;
- To request an accounting of Mount Sinai's disclosures of your medical information;
- To add an addendum to your medical record;
- To request that we communicate with you in a certain way or at a certain location;
- To receive a copy of the full version of our Notice of Privacy Practices.

### **Examples of how we may use and disclose your health information : (See Notice pp. 6-10)**

- To provide you with medical treatment and services;
- To bill and receive payment for the treatment and services you receive;
- For functions necessary to run Mount Sinai and to assure that our patients receive quality care;
- To provide only demographic information to our development office for purposes of fundraising for Mount Sinai;
- To support our research mission as an academic medical center with approval of Mount Sinai's Privacy Board;
- For workers' compensation or similar programs;
- For required public health activities (e.g., reporting abuse or adverse reactions to medications);
- For healthcare oversight (e.g., to the New York State Department of Health);
- For law enforcement in certain limited circumstances;

- To a coroner, medical examiner or funeral director as required by law;
- For organ procurement or transplantation, if you are a potential donor.

**For further information about the full Notice, please contact**

***Mount Sinai Hospital and Diagnostic and Treatment Center Privacy Officer at (212) 241-4669***

***Mount Sinai School of Medicine FPA Patient Rights Coordinator (212) 241-7715***

***Mount Sinai Hospital Queens Privacy Officer at (718) 267-4220***

***Northshore Medical Group Privacy Officer at (631)367-5125***



North Shore Medical Group



The Mount Sinai Hospital of Queens

A Division of The Mount Sinai Hospital



Diagnostic and Treatment Center

**ACKNOWLEDGEMENT of RECEIPT of NOTICE of PRIVACY PRACTICES (NOPP)**

*By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the Hospitals and facilities listed at the beginning of this Notice, and how I may obtain access to and control of this information.*

\_\_\_\_\_  
**Patient - Please PRINT Your Name -**

\_\_\_\_\_  
**Signature of Patient and/or Personal Representative**

\_\_\_\_\_  
**Personal Representative - Please PRINT Your Name**

\_\_\_\_\_  
**Description of Personal Representative's Authority**

*I was not able to obtain the patient's acknowledgement of receipt of the NOPP upon registration because:*

- The patient refused to sign despite good faith efforts.*
- The patient was unaccompanied and not alert and oriented.*
- The patient was unaccompanied and needed emergency care.*
- Other (explain) \_\_\_\_\_*

\_\_\_\_\_  
**Employee's Signature**

\_\_\_\_\_  
**Employee's Title**

\_\_\_\_\_  
**Print Your Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Acknowledgement subsequently obtained (Please see above.)**

## MOUNT SINAI DERMATOLOGY FPA

5 East 98<sup>th</sup> Street, 5<sup>th</sup> Floor, Box 1048  
New York, NY 10029  
(212) 241-9728



### OUR MISSION STATEMENT

*The mission of the Mount Sinai Dermatology Department is to provide superior comprehensive dermatologic care to our patients, exceed our patients' expectations in service and satisfaction, and advance the science of dermatology through research and education. Our Department is at the forefront of research and care in skin cancer, psoriasis, mycosis fungoides (cutaneous T cell lymphoma), eczema, acne, vitiligo, and in medical, surgical, and cosmetic dermatology.*

Administrative Office (212) 659-9530 ■ Fax (212) 348-7434  
E-mail: [Sinaidermatology@aol.com](mailto:Sinaidermatology@aol.com)  
Website: [www.mssm.edu/dermatology](http://www.mssm.edu/dermatology)

**Mark Lebowhl, MD**  
*Professor and Chairman*  
Department of Dermatology

**Marsha Gordon, MD**  
*Professor and Vice Chairman*  
Department of Dermatology

**Jacob O. Levitt, MD**  
*Associate Clinical Professor and Vice Chairman, Residency Director*  
Department of Dermatology

**Susan Bershad, MD**  
*Assistant Clinical Professor*  
Division, Pediatric and Adolescent Dermatology  
Department of Dermatology

**Hooman Khorasani, MD**  
*Assistant Clinical Professor*  
Chief, Division of Mohs, Reconstructive & Cosmetic Surgery  
Department of Dermatology

**Helen Shim-Chang, MD**  
*Assistant Professor, Dermatology and Dermatopathology*  
Director, Dermatopathology Lab  
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Medical Director, Faculty Practice Associates

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Director, Pigmented Lesions and Skin Care

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Director, Procedural Dermatology Program

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Director, Laser and Cosmetic Dermatology

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Director, Occupational & Contact Dermatitis  
Director, Laboratory for the Investigation of Inflammatory Skin Diseases

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*Professor of Dermatopathology*  
Director, Dermatopathology

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