

Advanced Breast & Cosmetic Surgery, Inc.

PATIENT REGISTRATION FORM

RESPONSIBLE PARTY / BILLING INFORMATION

LAST NAME _____
FIRST NAME _____
STREET ADDRESS _____
APT. NO. _____
CITY _____ STATE _____
ZIP CODE _____
TELEPHONE (____) _____
SSN _____

Address where billing statements/correspondence should be sent (if different than responsible party)

Telephone number where you want to receive calls about your appointment, test results or other health information* _____

Can confidential messages be left on your telephone answering machine or voicemail? YES NO

***Please be aware that a cell phone is not a secure and private line.**

PATIENT INFORMATION

LAST NAME _____
FIRST NAME _____
SSN _____ SEX _____
BIRTHDATE _____
RELATION TO INS. #1 _____
TELEPHONE (if different than responsible party) _____

CELL PHONE (____) _____

MARITAL STATUS: S M W D

EMPLOYER _____

EMP. PHONE _____

REFERRING DR. _____

REF DR ADDRESS _____

REF DR PHONE _____

FAMILY DR _____

FAMILY DR ADDRESS _____

FAMILY DR PHONE _____

PATIENT'S E-MAIL ADDRESS _____

May we send newsletters or information about services and products to your e-mail address? YES NO

INSURANCE INFORMATION

PRIMARY CARRIER _____

SUBSCRIBER _____

POLICY # _____

GROUP # _____

SUBSCRIBER DOB. _____

SUBSCRIBER EMPLOYER _____

CONDITION RELATED TO: Employment Y N ; Auto Accident Y N

SECONDARY CARRIER _____

SUBSCRIBER _____

POLICY # _____

GROUP # _____

SUBSCRIBER DOB. _____

SUBSCRIBER EMPLOYER _____

DATE OF INJURY _____

PATIENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND CLAIM PAYMENT AUTHORIZATION

I HEREBY AUTHORIZE THE ABOVE PHYSICIAN(S) TO RELEASE ANY INFORMATION REGARDING SERVICES RENDERED BY HIM AND ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO FILE INSURANCE.

DATE

PATIENT (PARENT OF GUARDIAN, IF MINOR)

I HEREBY AUTHORIZE AND DIRECT MY INSURED TO ISSUE PAYMENT CHECK(S) FOR BENEFITS DUE ME FOR THE SERVICES RENDERED BY THE ABOVE NAMED PHYSICIAN(S) TO BE MADE DIRECTLY TO HIM, REGARDLESS OF MY INSURANCE BENEFITS, IF ANY I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR THE FEES FOR SERVICES RENDERED.

DATE

RESPONSIBLE PERSON, POLICY OWNER, INSURED

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIAN AND PATIENT

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE MY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I REQUEST THE PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE FOR PHYSICIAN SERVICES TO THE PHYSICIANS OR ORGANIZATION FURNISHING THE SERVICE OR AUTHORIZE SUCH PHYSICIAN OR ORGANIZATION TO SUBMIT A CLAIM TO MEDICARE FOR PAYMENT TO ME. REQUEST THAT PAYMENT UNDER THE MEDICAL INSURANCE PROGRAM BE MADE EITHER TO ME OR TO THE ABOVE NAMED PHYSICIAN(S).

DATE

SIGNATURE

PATIENT QUESTIONNAIRE

- I.** Please list the family member or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name _____ Phone # _____
Name _____ Phone # _____

- II.** Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name _____ Phone # _____
Name _____ Phone # _____

- III.** I have received Advanced Breast & Cosmetic Surgery's Notice of Privacy Policy.

YES _____ NO _____

PATIENT NAME _____ (guardian if under 18 years)

PATIENT / GUARDIAN SIGNATURE

DATE

ADVANCED BREAST & COSMETIC SURGERY MEDICAL HISTORY

Patient: _____ Date: _____
 Reason for today's visit: _____ Referred by: _____
 _____ Primary Care Physician: _____
 Are you allergic to any medications? Yes No If yes, please list: _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

<u>Lungs:</u>	YES	NO	<u>Other Systemic:</u>	YES	NO
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary Embolus	<input type="checkbox"/>	<input type="checkbox"/>	Bowel	<input type="checkbox"/>	<input type="checkbox"/>

Vascular:

Cardiologist Name & Phone #: _____	Arthritis/Joint Deformity or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	Organ Transplant	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	Leukemia/Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	or other blood cancer	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	Neuromuscular disease	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	Height _____ Weight _____		
Bypass Surgery			
Deep Venous Thrombosis			

Do you drink alcohol? If YES _____ drinks per day

Do you use IV drugs? If YES, what? _____ How much?

Have you had or have you been exposed to HIV (AIDS)? YES NO

Have you ever had dental anesthesia (Novacaine)? YES NO Any bad reaction? YES

Are you allergic to latex YES NO

Have you ever had any surgeries? YES NO

Are you taking any medications, vitamins or herbal supplements?

<u>SURGERIES</u>	<u>DATE</u>	<u>MEDICATIONS</u>	<u>DOSAGE</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please answer the following questions:

- A. Do you smoke? YES NO If YES, how much? _____
- B. Do you bleed easily? YES NO
- C. (Women) Are you pregnant or nursing? YES NO Due Date: _____
- D. Do you have artificial joints, valves? YES NO
- E. What is your occupation? _____
- F. What are your hobbies? _____

OFFICE USE ONLY:

<input type="checkbox"/> All. AntiB.	<input type="checkbox"/> Bloodthinners	<input type="checkbox"/> Tobacco Use
<input type="checkbox"/> All. Anesth	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Hepatitis, HIV
<input type="checkbox"/> Cardiac HX	<input type="checkbox"/> Artif. Joint or Valve	<input type="checkbox"/> DM, Immunosup

Signed by Physician _____ Date _____

Reviewed by _____ Date _____

Advanced Breast & Cosmetic Surgery

**New Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment or Healthcare Operations**

I, _____, understand that as part of my health care, Advanced Breast & Cosmetic Surgery, Inc. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information services as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Advanced Breast & Cosmetic Surgery, Inc. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Advanced Breast & Cosmetic Surgery, Inc. reserves the right to change their notice, and in accordance with Section 164.520 of the Code of Federal Regulations, should Advanced Breast & Cosmetic Surgery change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and accept the terms of this consent.

Patient's Signature

Date