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 diiferent 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 QUESTIONAIRE

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)

Lungs:	**YES**	**NO**	**Other Systemic:**	**YES**	**NO**
Bronchitis	☐	☐	Diabetes	☐	☐
Emphysema	☐	☐	Thyroid	☐	☐
Asthma	☐	☐	Kidney	☐	☐
Chronic Cough	☐	☐	Bladder	☐	☐
Morning Cough☐	☐	☐	Stomach	☐	☐
Pulmonary Embolus	☐	☐	Bowel	☐	☐
			Hepatitis or Yellow Skin	☐	☐
Vascular:			Glaucoma	☐	☐
Cardiologist Name & Phone #:			Arthritis/Joint Deformity	☐	☐
_____			or Seizures	☐	☐
High Blood Pressure	☐	☐	Fainting	☐	☐
Chest Pain	☐	☐	Stroke	☐	☐
Heart Attack	☐	☐	Organ Transplant	☐	☐
Heart Murmur	☐	☐	Leukemia/Lymphoma	☐	☐
Irregular Heartbeat	☐	☐	or other blood cancer	☐	☐
Pacemaker	☐	☐	Neuromuscular disease	☐	☐
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?

SURGERIES	**DATE**	**MEDICATIONS**	**DOSAGE**

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:

☐ All. AntiB.	☐ Bloodthiners	☐ Tobacco Use
☐ All. Anesth	☐ Pacemaker	☐ Hepatitis, HIV
☐ Cardiac HX	☐ Artif. Joint or Valve	☐ 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 my 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