PATIENT REGISTRATION FORM

Welcome to Freed Plastic Surgery
In order to assist you properly, we will need the following information.

TODAY'S DATE ____________________

PATIENT'S NAME (last) ____________ (first)____________ (m.i.)______

IF CHILD, PARENTS NAME ____________________

ADDRESS ____________CITY ____________STATE ______ZIP ______

PHONE NUMBER ____________ (work / cell / emergency#) ____________

BIRTHDATE ____________SEX ______SOCIAL SECURITY # ____________

OCCUPATION ____________________

WHAT IS YOUR CHIEF COMPLAINT/CONCERN? ____________________

WHOM MAY WE THANK FOR REFFERRING YOU? ____________________

EMAIL ADDRESS ____________________

<u>*INSURANCE INFORMATION</u> (Non-cosmetic Procedures ONLY)

PATIENT STATUS:

Single Married Widowed Employed Retired Unemployed Full-time Student

PRIMARY INSURANCE ____________IDENTIFICATION# ____________

PATIENT'S RELATIONSHIP TO INSURED: Self Spouse Child Other____________

ADDRESS OF INSURED (if different from patient) ____________________

INSURED'S BIRTHDATE ____________________

SECONDARY COVERAGE ____________IDENTIFICATION# ____________

***ALL HMO'S (health maintenance organizations) require prior-authorization from a primary care physician before being seen.**

PRIMARY CARE DOCTOR ____________________

I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION NECESSARY TO EXPEDITE INSURANCE CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES THAT ARE NOT COVERED BY MY INSURANCE COMPANY.

X ____________________ DATE ____________

Signature of patient of parent if minor

PATIENT REGISTRATION FORM

PATIENT NAME ______________________________________DATE OF BIRTH ________________________

Do you smoke? If so, the type and amount ____

If former smoker, date quit ____

Weight ____Height _______________________________

Drug Allergies ____

List previous surgeries or major illnesses and dates ____________________________________

____

List any medications you are taking. Including non-prescription drugs, vitamins and herbals

____

____

FAMILY HISTORY

Has any blood relative ever had the following?

High Blood Pressure…… No Yes
Depression………...…… No Yes
Melanoma…………….. No Yes
Heart Disease….……… No Yes
Stroke…………………. No Yes
Kidney Disease……….. No Yes

PAST MEDICAL HISTORY

Have you ever had the following?

Heart Disease…………. No Yes
Arthritis……………..... No Yes
Rheumatic Fever……… No Yes
Anemia……………… No Yes
Tuberculosis………….. No Yes
Diabetes……………..… No Yes
Hepatitis……………… No Yes
Cancer……….……….. No Yes
Glaucoma……………… No Yes
Asthma………………… No Yes
AIDS or HIV+……….... No Yes
Stroke……………….…. No Yes
High Blood Pressure….. No Yes
Stomach Ulcer……..…. No Yes
Kidney Disease……..….. No Yes
Thyroid Disease……..… No Yes
Bleeding Tendency……. No Yes
Mitral Valve Prolapse… No Yes

REVIEW OF SYSTEMS

Do you have now or have you had in the past year?

Weight Change………... No Yes
Dry Eyes……………..... No Yes
Skin Rash……….……. No Yes
Chronic Diarrhea…...….. No Yes
Seizures……………..….. No Yes
Joint or muscle pain……. No Yes
Swollen Lymph Nodes… No Yes
Swollen Feet/Ankles….. No Yes
Rapid Heart Beat……... No Yes
Depression…………..…. No Yes
Chronic Cough…………..No Yes
Jaundice………………....No Yes
Easy Bleeding…………...No Yes
Easy Bruising…………...No Yes
Chest Pain…………….…No Yes

Women Only

Approximate date of last mammogram __________________________Number of pregnancies ________________________

Did you breast feed?__________________________________ Breast lump or discharge noted?________________________

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X____ _____________________________________
Signature of patient or parent if minor Date

FREED PLASTIC SURGERY MEDICAL CENTER

We have entered an age of extreme complexity in regard to the various insurance policies that each insurance company provides. Because of this, it has become necessary for our office to place the responsibility of understanding the requirements of your particular insurance policy on you. This includes, but is not limited to, knowing which facilities can be used for laboratory, hospitalization, or outpatient surgery. Also, it is critical that you notify our staff of any insurance changes you may have.

For surgical services, if the patient is responsible for co-payments, deductibles, non-covered services and/or amounts that insurance denies. If you have HMO insurance, we ask that you obtain a referral from your primary care physician before you schedule an appointment with our office. You may be held financially responsible if a referral/authorization is not obtained prior to your visit. Upon request, a payment arrangement may be discussed with our financial coordinator and reviewed for implementation.

After your consultation with Dr. Freed our Insurance Coordinator will contact your insurance company to determine if prior-authorization is required for the proposed procedure. **It can take up to 45 business days for your insurance company to process an authorization request.** Please do not schedule any further appointments or surgery prior to insurance approval.

Patients receiving cosmetic services must pay 10% down in order for our staff to schedule surgery. The remaining balance will be due 1-2 weeks prior to surgery.

After your cosmetic consultation with Dr. Freed our Patient Care Coordinator will send you a cost estimate along with a follow-up call to answer any questions or concerns that you may have.

Our staff is happy to assist you in any way that we can. However, if you are planning on utilizing your insurance company for any or all of the payment to Dr. Freed then please note that you are ultimately responsible for understanding your policy completely.

Please sign below stating that you understand this policy. Thank you for choosing Dr. Freed for your medical care. We are committed to providing the best possible care.

____ ______________________________
Patient Signature Date

____
Printed Name