



1567 Palisade Avenue, Third Floor
Fort Lee, New Jersey 07024

PATIENT REGISTRATION FORM

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ S.S.#: _____ Sex: M / F

Street Address: _____ City: _____ State: _____

Zip Code: _____ Telephone: _____ Cellular: _____

E-Mail: _____ Referred By: _____

(EMPLOYER'S INFORMATION)

Occupation: _____ Employer: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

(SPOUSE'S INFORMATION)

Spouse: _____ Date of Birth: _____ Age: _____

(SPOUSE'S EMPLOYER'S INFORMATION)

Occupation: _____ S.S.#: _____

Employer: _____ Telephone: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Primary Insurance: _____ I.D#: _____ Group#: _____

Insured Name: _____ Telephone#: _____ Relationship to Insured: _____

Secondary Insurance: _____ I.D#: _____ Group#: _____

Insured Name: _____ Telephone#: _____ Relationship to Insured: _____

In case of Emergency, contact: _____

(WORK)

Relationship: _____ Home: _____ Work: _____

I certify that the information given by me is correct. All information shared in this treatment is confidential except in circumstances governed by law (in accordance to HIPAA regulations). If you would like us to confer with another healthcare professional, you will need to sign a "Release of Information" form. I can revoke this permission at any time. I request that payment of authorized benefit be made directly to Palisade Plastic Surgery Assoc., Dr. Rosenberg, for medical services rendered by him. I understand that I am financially responsible for any balance not covered by my health insurance.

Signature: _____ Date: _____

(Patient or authorized person)

What is your main reason for the consultation?

PATIENT MEDICAL HISTORY:

Do you have any medical problems? No Yes
If Yes, Please explain:

Do you suffer from any of the following medical conditions, now or in the past?

High Blood Pressure No Yes

Diabetes No Yes

Heart Disease No Yes

High Cholesterol No Yes

Stroke No Yes

Thyroid Disease: No Yes

If Yes, (circle one) Hypoactive Hyperactive

Asthma: If Yes, Last Attack? No Yes

Lung Disease No Yes

Kidney Disease No Yes

Varicose Veins or DVT (Blood clots in leg veins)? No Yes

Cancer: No Yes

If Yes, Please specify type of cancer and treatment/year:

Melanoma No Yes

Have you ever had a blood transfusion? No Yes

Other (Please specify) No Yes

Do you exercise? No Yes

Have you ever had an ulcer? No Yes

Have you ever had Hepatitis? No Yes

If Yes, What type? (circle one) A B C

Have you been diagnosed with having HIV? No Yes

Have you ever been under the care of a psychiatrist or other mental health care professional? No Yes

If Yes, For what reason?

PAST SURGICAL HISTORY:

Have you had plastic surgery in the past? No Yes

Which type?

Name of plastic surgeon:

Town/City/Country:

Any complications? No Yes

If Yes, Please explain:

Have you had other surgery in the past? No Yes

Please list past surgeries and any complications of the surgery or anesthesia:

Procedure, Month/Year:

Doctor/Place:

Complication(s) if any:

Procedure, Month/Year:

Doctor/Place:

Complication(s) if any:

Are you allergic to any medication(s)?

No

Yes

Please explain which ones and what type of reaction you have:

FAMILY HISTORY:

Do any family members suffer from medical conditions:

No

Yes

Mother: (Specify Type of Illness: _____)

No

Yes

Father: (Specify Type of Illness: _____)

No

Yes

Brother(s): (Specify Type of Illness: _____)

No

Yes

Sister(s): (Specify Type of Illness: _____)

No

Yes

Children: (Specify Type of Illness: _____)

No

Yes

HEALING HISTORY:

Do you experience delayed healing of wounds?

No

Yes

Do you experience poor scarring? (Keloids, red or widespread scars)

No

Yes

Do you bruise easily?

No

Yes

ATTESTATION:

I certify that the information given by me is correct. I understand that false information given can be dangerous for my health. It is my responsibility to notify the physician and staff of any changes in my medical history.

Signature: _____

Date: ____ / ____ / ____

(NOTICE OF PRIVACY PRACTICE-HIPAA)

Palisade Plastic Surgery Associates, Inc. and Paul H. Rosenberg, M.D., P.C.

PATIENT ACKNOWLEDGEMENT

I acknowledge receipt and review of a copy of this Notice, and my understanding and my agreement to its terms. I have been offered a copy of this document to take home upon my request.

Patient

Date

INFORMED CONSENT

I authorize the release to my insurance carrier of any medical information necessary to process claims or necessary lab work. I also authorize release of my pathology results to my doctor utilizing all methods of transmission according to HIPAA regulations.

Signature: _____

FINANCIAL POLICY

Your payment is to be paid in full at the time of each session.

I hereby instruct and direct (insurance company) to pay back by check made out and mailed to Palisade Plastic Surgery Assoc., Paul H. Rosenberg MD, for the professional or medical expense benefits allowable, and otherwise payable to me under current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to Palisade Plastic Surgery Assoc., Paul H. Rosenberg, MD, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Agreement shall be considered as effective and valid as the original.

I authorize Palisade Plastic Surgery Assoc., Paul H. Rosenberg MD, and staff to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature: _____

INSURANCE REIMBURSEMENT AGREEMENT AND DISCLAIMER

I hereby certify that I understand there will be medical claims submitted to my Health Insurance Company on my behalf. These claims may represent services provided by Paul H. Rosenberg MD, the outpatient surgical facility of Palisade Plastic Surgery Associates Inc. and/or the anesthesiologist. These insurance claims are independent of any out of pocket payments made by me, and I understand that I am not to keep moneys paid by third party insurance carriers billed for these purposes.

I further understand that the doctor is not a participating provider with my insurance carrier and that reimbursement checks may be sent to me. I agree to forward any such payments upon receipt. I further agree that I am financially responsible for the full amount billed by any or all of the above parties plus 1.5% interest starting 30 days from documented receipt of such payments by me.

Patient's Name:

Date:

Patient's Signature:

Witness Signature: