

OVERLAKE PLASTIC SURGEONS

PATIENT REGISTRATION (PLEASE PRINT)

PATIENT NAME: _____ TODAY'S DATE: _____

ADDRESS: _____ CELLPHONE: _____

_____ HOME PHONE: _____

CITY STATE ZIP OTHER PHONE: _____

May we leave messages on any of these phone numbers? Yes No Which phone number is best? Cell Home Other

MALE FEMALE SINGLE MARRIED DIVORCED SEPARATED WIDOWED SIGNIFICANT OTHER

EMAIL: _____ DATE OF BIRTH: _____ AGE: _____

SOC, SEC, # _____ REFERRED TO THIS OFFICE BY: _____

PATIENT'S EMPLOYER: _____ SPOUSE'S NAME: _____

ADDRESS: _____ SPOUSE'S EMPLOYER: _____

_____ HOME PHONE: _____

_____ WORK PHONE: _____

PATIENT'S RELATIONSHIP TO PERSON RESPONSIBLE FOR BILL: SELF SPOUSE CHILD DEPENDENT

PERSON RESPONSIBLE FOR BILL, IF NOT PATIENT

NAME: _____

ADDRESS: _____

INSURANCE AND/OR INJURY INFORMATION

INSURANCE: _____ OTHER INSURANCE: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S NAME: _____

GROUP #: _____ GROUP #: _____

ID #: _____ ID #: _____

PATIENT'S RELATIONSHIP TO SUBSCRIBER: _____ PATIENT'S RELATIONSHIP TO SUBSCRIBER: _____

SELF SPOUSE CHILD DEPENDENT SELF SPOUSE CHILD DEPENDENT

SUBSCRIBER'S EMPLOYER: _____ SUBSCRIBER'S EMPLOYER: _____

IF INJURED: DATE: _____ PLACE THAT INJURY HAPPENED: HOME SCHOOL WORK AUTO

NATURE OF INJURY: _____

IN CASE OF EMERGENCY, LOCAL FRIEND OR RELATIVE TO BE NOTIFIED (NOT LIVING AT THE SAME ADDRESS)

NAME: _____ RELATIONSHIP: _____

CONTACT INFORMATION: HM PHONE #: _____ CELL # _____ WORK# _____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance company to release any information required for this claim.

I have received a copy of MICHAEL A. LEFF, MD, INC., P.S NOTICE FOR PRIVACY PRACTICES.

Do you wish to receive e-newsletters and cosmetic specials? Yes No

PATIENT SIGNATURE : _____ (Over)

Please read the statement below and sign the bottom.

PAYMENT POLICY

Our policy is to request payment at the time of the visit. First time, new patient cosmetic consults are always paid at the time of the visit.

You may have insurance that will cover part of all of your treatment, but please remember that you, the patient, are responsible for the total cost of our services to you.

If you have insurance, we will gladly work with you to help you receive your full benefit. If you provide us with complete information (ID numbers, address, etc.), we will bill your insurer for you. If the insurer should pay us for something you have already paid, we will, of course, refund the credit balance.

When a surgical procedure is scheduled, we must have verification of insurance coverage and when needed **pre-authorization PRIOR** to surgery. If you have a deductible or co-insurance with your coverage, you will be responsible for this amount upon completion of your insurance claim processing.

Surgeries not covered by insurance (this includes almost all cosmetic surgeries) must be paid in full at least seven day's prior to the surgery date.

If you are being represented by any attorney, please let us know in advance and sign appropriate releases for information. There are additional charges for records and letters prepared for litigation. Please discuss these with the doctor or patient coordinator. We cannot be placed in the middle of a conflict between two parties that may be settled by opposing insurers or attorneys in court. Therefore, in most situations, our fees are paid by the patient and recovered from the opposing parties.

We are happy to discuss fees and policies with you. Please do not hesitate discussing them with the doctor or patient coordinator.

I have read the above office policy statement, understand it and agree that I am responsible for charges incurred for treatments provided.

Patient or Responsibility Party

Date

MEDICAL HISTORY

Patient Name: _____ today's Date: _____

Height: _____ Weight: _____ Weight Change in past year: _____ LB Loss / Gain

Most Recent Physical Exam: _____ did this include an EKG? Yes No

Last Mammogram: _____

Are you allergic to any medications? Yes No if yes, please list: _____

Reason for this Visit: _____

Please list *all* medications you are now taking, include dosages:

Serious Illnesses (Please List):

Have you seen a Psychologist / Psychiatrist / Counselor? Yes No if yes, please specify reason:

Previous Surgery:

Operation

Year

Surgeons Name

Did you have any significant complications from any of these operations? Yes No

Are you pregnant? Yes No Are you nursing? Yes No Are you trying to get pregnant? Yes No

Have you had children? Yes No if yes, please list ages: _____, _____, _____, _____, _____, _____

Did you breast feed? Yes No

Have you been diagnosed with any of the following?

HIV? Hep C? Herpes? MRSA? (check all that apply)

Have you or a Family Member had any of the following:

Cancer	<input type="radio"/> Yes <input type="radio"/> No	kind of cancer? _____	<input type="radio"/> Self <input type="radio"/> Family Member _____
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Self <input type="radio"/> Family Member	_____
Heart Disease	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Self <input type="radio"/> Family Member	_____
High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Self <input type="radio"/> Family Member	_____
Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Self <input type="radio"/> Family Member	_____
Kidney Disease	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Self <input type="radio"/> Family Member	_____
Bleeding Disorders	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Self <input type="radio"/> Family Member	_____
Asthma	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Self <input type="radio"/> Family Member	_____
Autoimmune Disorder	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Self <input type="radio"/> Family Member	_____
Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Self <input type="radio"/> Family Member	_____
Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Self <input type="radio"/> Family Member	_____

Daily Consumption of the following:

Do you drink alcohol? Yes No _____

Do you smoke? Yes No _____ Social Smoker? Yes No _____ (smoking may adversely affect healing)

Recreational Drugs? Yes No (specify) _____

Are you a recovering alcoholic or drug user? Yes No (specify) _____

Please answer the following:

- Have you ever reacted badly to anesthesia after surgery? Yes No
- Have you required large amounts of anesthetic for procedures? Yes No
- Have you ever had a reaction to local anesthetic? Yes No
- Are you allergic to adhesive tape? Yes No
- Are you allergic to any suture material? Yes No
- Have you ever had scarlet fever or rheumatic fever? Yes No
- Do you bruise unusually easy? Yes No
- Are you a slow or poor healer? Yes No
- Do you form large scars or keloids? Yes No
- Do you have any skin issues like hives, eczema, rashes or boils? Yes No
- Do you have frequent infections of any kind? Yes No
- Have you taken steroid medications, cortisone or accutane? Yes No
- Do you have shortness of breath with walking? Yes No
- Does your religion prohibit blood transfusions? Yes No
- Have you ever had psychiatric care? Yes No
- Have you been advised to see a psychiatrist? Yes No

Have you had any illnesses or disorders of the following systems or organs?:

- Brain, including strokes, epilepsy Yes No
- Lungs, including asthma Yes No
- Eyes, including glaucoma, dryness Yes No
- Throat Yes No
- Breast Yes No
- Urinary System Yes No
- Nervous System Yes No
- Cardiovascular System Yes No
- Reproductive System Yes No
- Bones/Joints Yes No
- Blood Yes No
- Face, including paralysis Yes No
- Intestines Yes No
- Nose, including sinus Yes No
- Endocrine, including thyroid, diabetes Yes No

Patient Signature: _____

Parent or Guardian Signature if a Minor: _____