PATIENT REGISRATION

Last Name:	First Name:	Middle Initial

Address:	City:

State	Zip	Is Patient a Minor? ☐ Yes ☐ No	Relation to Patient ☐ Self ☐ Mother ☐ Father

Gender ☐ Male ☐ Female ☐ Other	Date of Birth	Age	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow

Cell Phone	Work/Home	Email

Employer/School Name	Occupation

Phone	Address

Emergency Contact	Relationship	Phone Number

If you are only interested in a Consultation for Plastic Surgery, Medical Insurance information is not necessary

Insurance Company Name	Policy Number

Are you the policy holder? ☐ YES ☐ NO If NO Policy Holders Name	Date of Birth
Referred by your Doctor? ☐ YES ☐ NO If YES Primary Doctors Name	Referral needed? ☐ YES ☐ NO

2ND Insurance Company Name	Policy Number

Are you the policy holder? ☐ YES ☐ NO If NO Policy Holders Name	Date of Birth
Referred by your Doctor? ☐ YES ☐ NO If YES Primary Doctors Name	Referral needed? ☐ YES ☐ NO

PLASTIC SURGERY CONSULTATION

IF YOU ARE NOT INTERESTED IN PLASTIC SURGERY, PLEASE SKIP GO TO THE NEXT SECTIONS

Height	Weight

What part of the body are you interested improving with cosmetic surgery?

Is this procedure a revision from a previous surgery? ☐ YES ☐ NO If yes, what type of surgery and what date?	Are you being referred by a Patient? ☐ YES ☐ NO If YES, please provide patients name

Have you consulted with other physicians about the above procedures before? ☐ YES ☐ NO

How did you hear about our office ☐ GOOGLE ☐ REALSELF ☐ OTHER, please list

Follow us on Instagram or SnapChat @realdrbody and @realdrface

REASON FOR INSURANCE VISIT

☐ Sinus Pain/Pressure	☐ Sore Throat	☐ Ear Pain/Pressure/Blockage	☐ Skin Moles/Growths
☐ Congestion/Postnasal Drip	☐ Trouble Swallowing	☐ Hearing Loss	☐ Breast Reduction/Reconstruction
☐ Nosebleed	☐ Horseness	☐ Ear Itchy	☐ Hernia Repair
☐ Nasal Fracture	☐ Neck Growth/Lump	☐ Dizziness/Tinnitus	☐ Eyes/Vision
☐ Sleep Disturbances/Snoring	☐ Other:		

Describe Symptoms:

Are you taking any medications for your symptoms? ☐ YES ☐ NO

CURRENT MEDICATIONS

☐ No know Current Medication

Please list all medications you currently take. Include all medications prescribed by a doctor as well as over-the-counter medications

1.	5.	9.
2.	6.	10.
3.	7.	11.
4	8.	12.

ALLERGIES

☐ Allergic to Latex ☐ No Known Allergy

ALLERGY	REACTION
1.	
2.	
3.	

PAST MEDICAL HISTORY - Please select the check box for each illness you have experienced in the past

☐ No Known Past Medical History

☐ High Blood Pressure	☐ Asthma	☐ Liver Disease	☐ Cancer – Type:
☐ Heart Disease	☐ Emphysema	Hepatitis ☐ A ☐ B ☐ C	☐ Glaucoma
☐ Heart Failure	☐ Pneumonia	☐ Gastric Reflux	☐ Cataract
☐ Heart Attack	☐ Bleeding Disorders with Clotting	☐ Stomach Problems	☐ Macular Degeneration
☐ Chest Pain	☐ Bleeding Disorders with Bleeding	☐ Ulcers	Thyroid ☐ Hyper ☐ Hypo
☐ High Cholesterol	☐ Phlebitis	☐ Stroke	☐ Psychiatric Diagnosis
Diabetes ☐ Type 1 ☐ Type 2	☐ Kidney Disease	☐ Seizure Disorder	☐ HIV or AIDS

Other Medical Condition not listed above:

FOR FEMALES ONLY

Is there a chance you may be pregnant? ☐ YES ☐ NO Last Menstrual Cycle, Date

Have you ever had a Mammogram ☐ YES ☐ NO If YES what date? Do you have a copy of the Mammogram Report? ☐ YES ☐ NO

PAST SURGICAL HISTORY

☐ No Known Surgical History

Have you had any previous surgeries, including cataract or laser eye treatments or procedures? If so, please list them all along with the date.

SURGERIES	DATE	SURGERIES	DATE

SOCIAL HISTORY

Do you use Aspirin or Ibuprofen ☐ YES ☐ NO Do you use Blood Thinners? (Examples: Coumadin, Heparin, Lovenox or Eliquis) ☐ YES ☐ NO

Have you had significant weight loss in the last year ☐ YES ☐ NO How much? ____________________

Are you a current smoker ☐ YES ☐ NO If YES, Number of packs per day? Are you a former Smoker ☐ YES ☐ NO

Do you drink any Alcoholic beverages ☐ YES ☐ NO If YES, How often How often? ____________________

Do you use Recreational drugs? ☐ YES ☐ NO If YES, What type of drug do you use? How often?____________________

FAMILY MEDICAL HISTORY

☐ No Known Family History

Please select the check box for each illness with in your family. Please indicate M for Mother, F for Father, S for Sibling, Select more than one if applicable.

☐ High Blood Pressure		☐ Asthma		☐ Hepatitis A		☐ Cancer	
☐ Heart Disease		☐ Emphysema		☐ Hepatitis B		☐ Glaucoma	
☐ Heart Failure		☐ Pneumonia		☐ Hepatitis C		☐ Cataract	
☐ Heart Attack		☐ Bleeding disorders-Clotting		☐ Gastric Reflux		☐ Macular Degeneration	
☐ Chest pain		☐ Bleeding Disorders-Bleeding		☐ Stomach Problems		☐ Hyperthyroidism	
☐ High Cholesterol		☐ Phlebitis		☐ Ulcers		☐ Hypothyroidism	
☐ Diabetes Type 1		☐ Kidney Disease		☐ Stroke		☐ Psychiatric Diagnosis	
☐ Diabetes Type 11		☐ Liver Disease		☐ Seizure Disorders		☐ HIV or AIDS	

Other Medical Condition not listed above

REVIEW OF SYSTEMS

Please indicate YES to all symptoms or conditions that you currently have. Indicate NO if you are not experiencing it. Do not leave any option blank.

EAR, NOSE and THROAT	Select YES or NO
Dizziness	O NO O YES
Ear Noises	O NO O YES
Hearing Loss	O NO O YES
Hoarseness	O NO O YES
Nasal Congestion	O NO O YES
Nosebleed	O NO O YES
Postnasal Drip	O NO O YES
Sinus Pressure/Pain	O NO O YES
Sneezing	O NO O YES
Throat Pain/Dryness	O NO O YES
RESPIRATORY	Select YES or NO
Coughing Blood	O NO O YES
Shortness of Breath	O NO O YES
Weakness	O NO O YES
NEUROLOGY	Select YES or NO
Headache	O NO O YES
Passing Out	O NO O YES
PSYCHIATRIC	Select YES or NO
Anxiety	O NO O YES
Depression	O NO O YES

SKIN	Select YED or NO
Growths/Moles	O NO O YES
Rash	O NO O YES
Skin Cancer	O NO O YES
Skin or Hair Changes	O NO O YES
HEMATOLOGIC/LYMPHATC	Select YES or NO
Bleeding Problems	O NO O YES
Easy Bruising	O NO O YES
Swollen Glands	O NO O YES
GASTROINTESTINAL	Select YES or NO
Diarrhea	O NO O YES
Difficulty Swallowing	O NO O YES
Heartburn	O NO O YES
Vomitting	O NO O YES
CARDIOLOGY	O NO O YES
Chest Pain	O NO O YES
Heart Murmur	O NO O YES
Palpitations	O NO O YES
MUSCULOSKELETAL	O NO O YES
Leg Swelling	O NO O YES
Muscle/Joint Aches	O NO O YES
EYES	Select YES or NO
Eye Pain	O NO O YES
Watery/Itchy Eyes	O NO O YES

Patient Signature

Date

PRIVACY PRACTICES and BILL of RIGHTS

I understand and acknowledge that the Notice of Privacy and the Patient's Bill of right are available for me to read. I understand I have rights and give my permission to Associates in Plastic Surgery, ENT Specialists of NJ and Ophthalmology Associates to use and disclose my health information in accordance with rendering or securing payment for professional services.

I understand that a copy of the Notice of Privacy Practices and the Patient's Bill of Rights are available upon request.

____
Name of Patient (please print)

____
Date

____
Signature of Patient

____
Date

____
Relation to Patient
(ex. Mother, Father, Guardian or Self)

AGREEMENT TO PAY AND RIGHTS OF EACH PATIENT

I acknowledge that I am responsible for payment of medical services rendered by Andrew J Miller, MD, Elliot Heller, MD, Harry T. Haramis, MD, Julis A. Sullivan Miller, MD, PhD. Also known as Associates in Plastic Surgery, ENT, PA, Allure Plastic Surgery, ENT, PC, ENT Specialist of NJ, LLC and Ophthalmology Associates, LLC, regardless of any reimbursement to which I may be entitled by reason of insurance or legal claims. I am aware that it is my sole responsibility to know in advance of the services rendered, the benefits and guidelines of my individual insurance coverage; to obtain all necessary insurance referral forms and/or pre-certification and to confirm with my insurer the participatory status of this providers.

I authorize the above providers to prepare and submit the appropriate claim forms to my primary and secondary insurance carrier (s). I hereby assign all insurance benefits relating to these medical services to. Andrew J Miller, MD, Elliot Heller, MD, Harry T. Haramis, MD, Julis A. Sullivan Miller, MD, PhD. Also known as Associates in Plastic Surgery, ENT, PA, Allure Plastic Surgery, ENT, PC, ENT Specialist of NJ, LLC and Ophthalmology Associates, LLC. I authorize the release of all information which is necessary to ensure payment of these benefits.

I understand that I am responsible for any services that are not covered by my insurance. Even though payment may be sent directly to the above providers, I understand that I am still responsible for any remaining balance (example: co-insurance, deductible, etc). Payment arrangements with the billing representatives. I understand my financial obligations to this practice for services rendered on my behalf that if I fail to keep any financial obligations, I agree to pay all costs pertaining to the collection of outstanding fees including collection agencies and attorney fees, up to 50% added to the principal balance.

I hereby acknowledge that I have been offered a written copy of the "Rights of Each Patient" and I further acknowledge and understand the explanation given to me about my rights.

____ ____________________________

Signature of Patient Date

EDISON, NJ 08837	MARLBORO TWP, NJ 07726	WARREN, NJ 07059	WEST ORANGE, NJ 07052
TEL. 732-548-3200	TEL. 732-617-1800	TEL. 908-222-8440	TEL. 973-609-5979
FAX 732-548-3200	FAX 732-617-9743	FAX 908-222-8122	FAX 973-325-0872

PROCEDURE INFORMED CONSENT

I understand that my doctor may perform one or more small procedures as part of any office visit. These procedures may include wax removal, hearing test, or visualization of the nose and throat with order to complete a full evaluation of symptoms, and as a specialist, these can provide valuable diagnostic information that can ultimately help my condition. I therefore give consent to have these diagnostic procedures done so that I have the best chance possible of having a successful treatment course.

____ ____________________
Patient Signature Date

____ ____________________
Witness (office Staff) Date