ASSOCIATES IN PLASTIC SURGERY

PLEASE **PRINT CLEARLY AND MAKE SURE TO **ANSWER ALL FIELDS****

Name: [First] ___________________________ [M.I] ____ [Last] ___________________________________ □ Male | □ Female

Address: ____[Apt.] _________ **D.O.B:** ____/____/____ Age: _______

City: ___________________________________ **State**: __________ **Zip**: ____________ Social Sec #: ______________________

Home Tel: _________________________ **Cell Phone**: ________________________ Marital Status: □ Single | □ Married | □ Other

Drivers License# _____________________________________ **Email Address**: ____

If Patient is a minor, Parent / Legal Guardian Name: ____

Relationship to patient: _______________________________

EMPLOYMENT INFORMATION

□ Full Time | □ Part Time | □ Student | □ Retired | □ Other Occupation: _______________________________________

Employer / School: _____________________________________ Work#:____

Work/School Address: __________________________________ City: ______________________ State: ______ Zip: ____________

SPOUSE CONTACT

[If applicable]

Name: [First] ____________________________ [Last] ________________________________ Phone #: ______________________

EMERGENCY CONTACT

MUST LIST AN EMERGENCY CONTACT

Name: [First] ____________________________ [Last] ________________________________**Phone** #: ______________________

Relationship to patient: ____

INSURANCE INFORMATION

If you have an HMO policy and your Insurance plan requires a referral, it is your responsibility to obtain this documentation prior to your visit.

Primary Insurance Name: ________________________________ ID # ___________________________ Group#_____________

Name of Policy Holder: [First] _____________________________ [Last] __________________________ D.O.B: : ____/____/____

Relationship to Policy Holder __________________________________ Insurance Telephone #: ____________________________

Does your Insurance require a referral? □ YES | □ NO

Secondary Insurance Company [*if applicable*] ________________________________ ID # ________________________________

Name of Policy Holder: ____________________________ Relationship to Policy Holder: ______________ D.O.B: : ____/____/____

Primary Doctor Name: ____ Phone #: ______________________________

Address: ____ City: ______________________ Zip: ______________________

I understand that office charges and co-pays are payable on the day service is rendered. I authorize the release of all medical information necessary to process insurance claims and am aware that the deductibles, co-insurance and any non-covered services are ultimately my responsibility. I also understand that all bills must be paid in a timely manner.

Signature: [Patient, Parent or Guardian] ____ Date:__________________

ASSOCIATES IN PLASTIC SURGERY

REFERRAL INFORMATION

Are you being referred by a Physician or Patient? □ Yes | □ No // If yes, please provide name: ______________________________

How did you hear about our office? □ Google | □ Realself | □ Facebook | □ Insurance | □Other: _________________________

Have you been to our website [www.associatesinplasticsurgery.com] □ Yes | □ No If yes, was our website helpful? □ Yes | □ No

If No, please list reason: ____

____

PROCEDURE INFORMATION

What is the reason for your visit today? [Check all applicable procedures below]

Please be advised that the Doctor you are seeing may not practice all of these procedures.

FACE	BREAST	BODY	SKIN / MISC.
□ Face Lift □ Rhinoplasty □ Mini Face Lift □ Cheek Lift □ Brow Lift □ Neck Lift □ Upper Blepharoplasty □ Lower Blepharoplasty □ Chin Augmentation □ Otoplasty / Ear Reshaping □ Facial Fat Transfer □ Hair Transplant **Other:** __________________	□ Breast Augmentation □ Breast Lift (Mastopexy) □ Breast Revision / Repair □ Breast Implant Exchange □ Breast Reduction □ Breast Reconstruction □ Male Breast Reduction **Other:** __________________	□ Liposuction □ Tummy Tuck □ Mommy Makeover □ Body Lift □ Buttock Augmentation □ Arm Lift □ Thigh Lift □ Fat Transfer □ Male Enhancement □ Abdominal Etching	□ Botox □ Juvederm □ Restylane □ Radiesse □ Silicone □ Skin Resurfacing □ Chemical Peels □ Laser Hair Removal □ Earlobe Repair □ Mole Removal □ Schlero □ Coolsculpting □ Tattoo Removal □ Kybella

Have you consulted with other physicians about the above procedures before? □ Yes | □ No

Is this procedure a revision from a previous surgery? □ Yes | □ No If Yes, how many previous surgeries? _______________

Have you had blood drawn in the past month? □ Yes | □ No If yes, location: ___________________

Have you had and EKG done in the last year? □ Yes | □ No If yes, location: ___________________

When was your last Mammogram ? [*if applicable*] _________________________

Is there a personal or family history of anesthetic complications or malignant hyperthermia? □ Yes | □ No

If yes, please explain: ____

SURGERY SCHEDULING QUESTIONAIRE

To help us understand your particular needs and time preferences for your surgery, please provide us with the following information:

What is the time preference for your Procedure? Within the next: □ Month | □ 3 Months | □ 6 Months | □ 1 Year

Does your home or work schedule permit such flexibility whereby you could have your cosmetic surgery done on “short notice”,
i.e. 10-14 days advance notice ? □ Yes | □ No

ASSOCIATES IN PLASTIC SURGERY

MEDICAL HISTORY

PATIENT INFORMATION

Name: ____ **Age:** ______ **Weight:** ________ **Height:** ________

Last Menstrual Cycle[*if applicable*]: _________________ Is there a chance you may be pregnant? □ Yes | □ No

PERSONAL PAST HISTORY

Do you have any chronic medical problems? [*Check box for those that apply*]

□ High Blood Pressure	□ Diabetes	□ HIV or Aids	□ Cancer
□ Heart Disease	□ Kidney Disease	□ Hepatitis (A, B, C)	□ Ulcers
□ Heart Failure	□ Psychiatric Diagnosis	□ Stroke	□ Pneumonia
□ Seizures	□ Bleeding Problems	□ Emphysema	□ Phlebitis
□ Heart Attack	□ Liver Disease	□ Stomach Problems	
□ Chest Pain	□ Gastric Reflux	□ Asthma	

Other Medical Condition not listed above: ____

FAMILY HISTORY

Do you have a family history of any medical problems? [*Check box for those that apply*]

□ High Blood Pressure	□ Diabetes	□ HIV or Aids	□ Cancer
□ Heart Disease	□ Kidney Disease	□ Hepatitis (A, B, C)	□ Ulcers
□ Heart Failure	□ Psychiatric Diagnosis	□ Stroke	□ Pneumonia
□ Seizures	□ Bleeding Problems	□ Emphysema	□ Phlebitis
□ Heart Attack	□ Liver Disease	□ Stomach Problems	
□ Chest Pain	□ Gastric Reflux	□ Asthma	

Other: ____

Please Indicate Family member: ____

Please list all prior Operations:	**Date**	**List any complications:**
1. ________________________________	____/____/_____	___________________________________
2. ________________________________	____/____/_____	___________________________________
3. ________________________________	____/____/_____	___________________________________

Please List ALL medications and/or dietary supplements including:

(Prescriptions, over the counter medicines, Aspirin, Vitamins and Herbal Supplements you may be taking)

1.________________________________	4. ________________________________	7. ____________________________
2.________________________________	5. ________________________________	8. ____________________________
3.________________________________	6. ________________________________	9. ____________________________

Please list ALL allergies and describe reactions(i.e. shellfish, latex, penicillin, nut):

1.____

2.____

3.____

ASSOCIATES IN PLASTIC SURGERY

PATIENT INTAKE FORM

Review of the Systems:
Please answer the following Yes or No questions to the best of your ability. Do you have any of the following conditions, illnesses or symptoms?
Please Check box if your symptoms are related to todays visit

ALLERGY	Sneezing	□	Yes | No	ENDO	Diabetes	□	Yes | No
	Hearing Loss	□	Yes | No		Hyperthyroidism	□	Yes | No
	Nasal Congestion	□	Yes | No		Hypothyroidism	□	Yes | No
	Hoarseness	□	Yes | No		Hypoglycemia	□	Yes | No
	Dizziness	□	Yes | No		High Cholesterol	□	Yes | No
	Post Nasal Drip	□	Yes | No	SKIN	Rash	□	Yes | No
	Ear Noises	□	Yes | No		Skin or Hair Changes	□	Yes | No
	Sinus Pressure/Pain	□	Yes | No		Moles/Growth	□	Yes | No
	Throat Pain/ Dryness	□	Yes | No		Hives	□	Yes | No
RESPIR	Cough	□	Yes | No	HEME/LYM	Swollen Glands	□	Yes | No
	Shortness of Breath	□	Yes | No		Sweating at Night	□	Yes | No
	Coughing Blood	□	Yes | No		Easy Bruising	□	Yes | No
	Wheezing	□	Yes | No		Bleeding Problems	□	Yes | No
	Sleep Apnea	□	Yes | No		Anemia	□	Yes | No
	Asthma	□	Yes | No		Sickle Cell	□	Yes | No
NEURO	Headache	□	Yes | No	GASTRO	Vomiting	□	Yes | No
	Passing Out	□	Yes | No		Heart Burn	□	Yes | No
	Stroke	□	Yes | No		Diarrhea	□	Yes | No
	Seizures	□	Yes | No		Difficulty Swallowing	□	Yes | No
	Sciatica	□	Yes | No	CARDIAC	Chest Pain	□	Yes | No
PSYCH	Depression	□	Yes | No		Palpitations	□	Yes | No
	Mental Health	□	Yes | No		Heart MurMur	□	Yes | No
	Problems	□	Yes | No	MSK	Muscle/Joint Aches	□	Yes | No
EYES	Anxiety	□	Yes | No		Leg Swelling	□	Yes | No
	Eye Pain	□	Yes | No		Frequent Urination	□	Yes | No
	Watery / Itchy Eyes	□	Yes | No		Painful Urination	□	Yes | No

SOCIAL HISTORY

Do you use aspirin or medications containing Aspirin or Ibuprofin? □ Yes | □ No

Do you use Blood Thinners? (i.e.: Coumadin, Heparin) □ Yes | □ No

Have you had a significant weight loss in the past year? □ Yes | □ No Amount Lost? ___________

Have you used Diet Pills in the last 2 months? □ Yes | □ No

Have you taken Steroids in the last year? □ Yes | □ No

Have you ever smoked tobacco products? □ Yes | □ No

If yes, Number of packs per day _____________ Number of years: ________ If you quit, when? _________________________

Do you consume alcoholic beverages? □ Yes | □ No If yes, Amount Weekly? __________________

Do you use recreational drugs? □ Yes | □ No If yes, list type: _________________________

Do you have caps, bridges, dentures, or loose teeth? □ Yes | □ No If yes, list type: _________________________

Thank you for providing this important information!

____

[Patient/Parent/Guardian Signature] Date: ____/____/_____

Associates in Plastic Surgery, ENT, PA
Allure Plastic Surgery, ENT, PC
Plastic Surgery Specialist of NJ, LLC
Ophthalmology Associates, LLC

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, Shain A. Cuber, MD, Julia A. Sullivan, MD, PhD. Also known as Associates in Plastic Surgery, ENT, PA, Allure Plastic Surgery, ENT, PC, Plastic Surgery Specialists of NJ, LLC and Ophthalmology Associates, LLC, regardless of any reimbursements to which I may be entitled by reason of insurance or legal claims. I am aware that it solely my 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 these providers.

I authorize the above providers to prepare and submit the appropriate claims 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 M. Heller, MD, Shain A. Cuber, MD, Julia A. Sullivan, MD, PhD, Associates in Plastic Surgery, ENT, PA, Allure Plastic Surgery, ENT, PC, Plastic Surgery Specialists of NJ, LLC and or Ophthalmology Associates, LLC. I authorize the release of all information necessary to collect payments of medical services.

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 balance remaining (example: co-insurance, deductible etc.) Payment arrangements can be made with the billing representatives. I understand my financial obligations to this practice for services rendered on my behalf. 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,

I herby 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.

- I have reviewed the Notice of Privacy Practices. In addition, I read the Patient's Bill of Rights and give my permission to **Associates in Plastic Surgery, E.N.T., and P.A & Ophthalmology Associates LLC, E.N.T. Specialists of NJ, LLC, and Plastic Surgery Specialists of NJ, LLC** to use and disclose my health information in accordance with rendering and 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.

____________________________________ ______________________
Signature of Patient or Legal Guardian Date

____________________________________ ______________________
Signature of Witness Date