PATIENT REGISTRATION

Patient Name:	Date of Birth:	Age:	Sex:
Marital Status:	Patient a Minor? ☐ YES ☐ NO	Parents/Legal Guardian:	
Address:	City:	State:	ZIP
Cell Phone: Home/Work Phone:		Email	
Emergency Contact		Relation	

EMPLOYMENT/SCHOOL

Please complete

Occupation	Employer/School Name
Phone	Address

INSURANCE

Please complete the Insurance questions

Insurance Company Name Policy Number

Are you the policy holder? ☐ YES ☐ NO If NO Policy Holders Name Date of Birth

Referred by your Insurance Company? ☐ YES ☐ NO If Yes name Referral needed? ☐ YES ☐ NO

Referred by your Doctor? ☐ YES ☐ NO If YES name Primary Doctors Name

SECONDARY INSURANCE

Please complete the Insurance questions

Insurance Company Name Policy Number

Are you the policy holder? ☐ YES ☐ NO If NO Policy Holders Name Date of Birth

Referred by your Insurance Company? ☐ YES ☐ NO If Yes name Referral needed? ☐ YES ☐ NO

Referred by your Doctor? ☐ YES ☐ NO If YES name Primary Doctors Name

PLASTIC SURGERY CONSULTATION

IF YOU ARE NOT INTERESTED IN PLASTIC SURGERY, PLEASE SKIP THE NEXT TWO SECTIONS AND CONTINUE ON TO THE SECTION REASON FOR INSURANCE VISIT BELOW

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?

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

Height Weight

HOW DID YOU HEAR ABOUT US?

Are you being referred by a Patient? ☐ YES ☐ NO If YES, please provide patients name

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

Have you been to our website? ☐ YES ☐ NO | If Yes, was our website helpful? ☐ YES ☐ NO

If our website was NOT helpful, please explain so we can make future improvements.

Follow us on Instagram or SnapChat @realdrbody and @realdrface

SURGERY SCHEDULING

If you would like to schedule surgery following your visit, please advise our staff

How would you prefer us to contact you? ☐ Telephone ______________________________ ☐ Email ______________________________

Would you be interested in hearing from us about future promotions, new procedures or products ☐ YES ☐ NO

SOCIAL MEDIA

Are you on Social Media? ☐ YES ☐ NO Email

☐ Facebook ______________________________ ☐ Instagram ______________________________ ☐ SnapChat ______________________________

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

If yes please list all medications below ↓

CURRENT MEDICATIONS

Please list all medications you currently take. Include all medications prescribed by a doctor as well as over-the-counter medications and include all vitamins and dietary supplements as well.

1	6		11	
2	7		12	
3	8		13	
4	9		14	
5	10		15	

☐ No know Current Medication

ALLERGIES

Do you have allergies? If so, please list them all and describe your reaction for each allergy.

	ALLERGY	REACTION
1		
2		
3		
4		
5		

☐ Allergic to Latex

☐ No Known Allergy

PAST MEDICAL HISTORY

Please select the check box for each illness you have experienced in the past (Select more than one if necessary)

☐ 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:

☐ No Known Past Medical History

FOR FEMALES ONLY

Last Menstrual Cycle, Date

Is there a chance you may be pregnant? ☐ YES ☐ NO

Have you ever had a Mammogram ☐ YES ☐ NO

If YES what date?

Do you have a copy of the Mammogram Report? ☐ YES ☐ NO

FAMILY MEDICAL 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

☐ No Known Family History

PAST 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 and the Doctor who did the surgery.

SURGERIES	DATE	Surgeon who did the Surgery	SURGERIES	DATE	Surgeon who did the Surgery

☐ No Known Surgical History

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	SKIN	Select YED or NO
Dizziness	○ NO ○ YES	Growths/Moles	○ NO ○ YES
Ear Noises	○ NO ○ YES	Rash	○ NO ○ YES
Hearing Loss	○ NO ○ YES	Skin Cancer	○ NO ○ YES
Hoarseness	○ NO ○ YES	Skin or Hair Changes	○ NO ○ YES
Nasal Congestion	○ NO ○ YES	**HEMATOLOGIC/LYMPHATC**	Select YES or NO
Nosebleed	○ NO ○ YES	Bleeding Problems	○ NO ○ YES
Postnasal Drip	○ NO ○ YES	Easy Bruising	○ NO ○ YES
Sinus Pressure/Pain	○ NO ○ YES	Swollen Glands	○ NO ○ YES
Sneezing	○ NO ○ YES	**GASTROINTESTINAL**	Select YES or NO
Throat Pain/Dryness	○ NO ○ YES	Diarrhea	○ NO ○ YES
RESPIRATORY	Select YES or NO	Difficulty Swallowing	○ NO ○ YES
Coughing Blood	○ NO ○ YES	Heartburn	○ NO ○ YES
Shortness of Breath	○ NO ○ YES	Vomitting	○ NO ○ YES
Weakness	○ NO ○ YES	**CARDIOLOGY**	○ NO ○ YES
NEUROLOGY	Select YES or NO	Chest Pain	○ NO ○ YES
Headache	○ NO ○ YES	Heart Murmur	○ NO ○ YES
Passing Out	○ NO ○ YES	Palpitations	○ NO ○ YES
PSYCHIATRIC	Select YES or NO	**MUSCULOSKELETAL**	○ NO ○ YES
Anxiety	○ NO ○ YES	Leg Swelling	○ NO ○ YES
Depression	○ NO ○ YES	Muscle/Joint Aches	○ NO ○ YES
		EYES	Select YES or NO
		Eye Pain	○ NO ○ YES
		Watery/Itchy Eyes	○ NO ○ YES

SOCIAL HISTORY

Do you use Aspirin or medications containing 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 Have you used diet pills in the last 2 months ☐ YES ☐ NO

Have you taken steroid☐ YES ☐ NO

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

Are you a former Smoker ☐ YES ☐ NO If YES, When did you quit?

Do you drink any Alcoholic beverages ☐ YES ☐ NO If YES, How much? How often? ☐ daily ☐ weekly ☐ monthly

What type of alcohol? ☐ Wine ☐ Beer ☐ Spirits ☐ Hard Liquor

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

How often? ☐ daily ☐ weekly ☐ monthly

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, 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,ENT Specialist 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, Harry T. Haramis, 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, up to 50% added to 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.

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, Allure Plastic Surgery, 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

(office staff)