BeverlyFriedlanderMD
Plastic Surgery
638 Morris Turnpike, Suite 1A Short Hills, NJ 07078
t: 973-912-9120 f: 973-912-8070 Info@DoctorBev.com

PATIENT INFORMATION:

(PLEASE PROVIDE A COPY OF YOUR PHOTO ID(as required by the FCC 11/1/09)

Name_____ Age_____ Birthdate_____
Last First Middle Initial

Patient's Social Security #_____ Patient's Driver License#_____

Home Address: _____
Street Apt Number

City:_____State:_____Zip Code:_____

Home Phone: (_____)_____ Cell :(_____)_____ Work (_____)_____

Best Contact Number (Please Circle One): Home Cell Work

E-Mail Address_____

Employer_____ Occupation_____

Employer Address_____
Street City State ZipCode

Name Of Responsible Party (If Other Than Patient)_____Relationship_____

Emergency Contact_____

Relationship_____ Phone(____)_____

How Did You Hear About Our Office? Referred By: ☐ Internet ☐ Magazine ☐ Social Media

Please List Name If Referred by Friend / Employee / Current Patient / Other:_____

Primary Reason For Consultation:_____

Are you Interested in any of the following:

☐ Brow Lift	☐ Breast Augmentation	☐ Coolsculpting	☐ Brazilian Butt Lift
☐ Face Lift	☐ Breast Lift	☐ Liposuction	☐ Vaginoplasty
☐ Eyelid Surgery	☐ Breast Reduction	☐ TummyTuck	☐ Lasers
☐ Ear Surgery	☐ Mommy Makeover	☐ Other Body Contouring	☐ Brown Spots
☐ Fillers/Botox	☐ Breast Reconstruction	☐ Gynecomastia	☐ Ultherapy

Have you consulted other physicians and/ or Plastic Surgeons for this?
If yes, Whom?_____

FINANCIAL RESPONSIBILITY:

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and cost of collection in the event of default.

_____ _____
Signature of Responsible Party Today's Date

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MEDICAL HISTORY:

Name_____ Date_____

Date of Last Physical Examination_____ Weight_____ Height_____

Name of Primary Care Physician_____

Address of Physician_____Phone_____

MEDICAL CONDITIONS- HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Please Check All that Apply

☐ Heart Disease	☐ Shortness of Breath	☐ Eye Disorder/Glaucoma	☐ Diabetes/Pre Diabetes
☐ High Cholesterol	☐ Asthma	☐ Seizures/Stroke	☐ Thyroid
☐ High Blood Pressure	☐ Lung Problems	☐ Headaches/Migraines	☐ Hepatitis/ Liver
☐ Reflux/Ulcer	☐ Sinus Problems	☐ Neurological Problems	☐ Arthritis
☐ Anemia/Blood Problems	☐ Seasonal Allergies	☐ Depression/Anxiety	☐ Muscle/Bones
☐ Swollen Ankles	☐ Ear Problems	☐ Psychiatric Care	☐ Colitis
☐ Vascular (Blood Vessels)	☐ Reproductive Organs	☐ Auto-Immune Disorder	☐ Scars/Skin

Please Explain All:

_____

_____

REVIEW OF SYSTEMS:

Are you currently experiencing any problems that were not identified above?

☐ Weight Gain or Loss	☐ Lung	☐ Muscles/Bones	☐ Thyroid
☐ Head	☐ Heart	☐ Reproductive System	☐ Skin Diseases
☐ Eyes	☐ Blood Pressure or Vessels	☐ Kidney/Bladder	☐ Swollen Glands/Lymph Nod
☐ Ears	☐ Digestive System	☐ Liver	☐ Depression

Please Explain All:

_____

_____

PREVIOUS SURGERY (OPERATIONS AND COSMETIC SURGERY) or HOSPITALIZATIONS

Type Date Complications or Difficulties

1._____

2._____

3._____

4._____

5._____

MEDICATIONS, VITAMINS OR HERBAL SUPPLEMENTS YOU ARE CURRENTLT TAKING:

Name Dose(mg) Frequency

1._____ 5. _____

2._____6._____

3._____7._____

4._____8._____

ALLERGIES:

Yes☐ No☐ Please List._____

DO YOU USE THE FOLLOWING?

Aspirin?	Yes☐ No☐	Amount Daily_____ Amount Weekly_____
Motrin, Alleve, Advil?	Yes☐ No☐	Amount Daily_____ Amount Weekly_____
Alcohol?	Yes☐ No☐	Amount Daily_____ Amount Weekly_____
Recreational Drugs?	Yes☐ No☐	Amount Daily_____ Amount Weekly_____
Steroids?	Yes☐ No☐	Amount Daily_____ Amount Weekly_____
Cigarettes?	Yes☐ No☐	Amount Daily_____ ____ Amount Weekly_____
Have You Ever Smoked?	Yes☐ No☐	When Did You Quit?_____

HAVE YOU EVER HAD A PROBLEM WITH ANY OF THE FOLLOWING?

Bleeding Problems?	Yes☐ No☐
Blood Transfusion?	Yes☐ No☐
Local or General Anesthesia?	Yes☐ No☐
Emotional problems?	Yes☐ No☐
Psychiatric problems?	Yes☐ No☐
Allergy to Latex or tape?	Yes☐ No☐
Scars?	Yes☐ No☐

PLEASE EXPLAIN:

_____

HAVE YOU EVER HAD, HAVE OR BEEN EXPOSED TO:

Intravenous Drugs	Yes☐ No☐
Infectious Diseases	Yes☐ No☐
TB	Yes☐ No☐
HIV / Aids	Yes☐ No☐
Hepatitis	Yes☐ No☐

PLEASE EXPLAIN :

_____

FAMILY HISTORY

Any Family History of Medical Problems?

☐Breast Cancer	☐High Blood Pressure	☐Kidney Disease
☐Melanoma	☐Heart Disease	☐Depression
☐Stroke	☐Diabetes	☐Other

WOMEN ONLY:

Age Period Began: _____ Stopped?_____ Number Of Pregnancies_____

Number Of Children_____ Are You Planning More Children? Yes☐ No☐

If Applicable, Date Of Last Mammogram?_____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE THE RELEASE OF ANY INFORMATION, PERSONAL OR MEDICAL, NECESSARY TO PROCESS THIS CLAIM.

_____ _____ _____

Signature of patient or Guardian if patient is minor | Relationship | Date

I CONSENT TO THE TAKING OF PHOTGRAPHS PRIOR TO DURING AND AFTER SURGERY FOR THE PURPOSE OF MEDICAL DOCUMENTATION.

_____ _____ _____

Signature of patient or Guardian if patient is minor | Relationship | Date

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INSURANCE INFORMATION:

PRIMARY:

Insurance Company:_____Tel #:_____

Claims Address:_____

ID #_____Group #/ Plan #_____

Insured's Address:_____ City State Zip:_____

Insured's Phone:_____ Insured's Employer:_____

Insured's Date of Birth:_____ Insured's SS#:_____

SECONDARY:

Insurance Company:_____Tel #:_____

Claims Address:_____

ID #_____Group #/ Plan #_____

Insured's Address:_____ City State Zip:_____

Insured's Phone:_____ Insured's Employer:_____

Insured's Date of Birth:_____ Insured's SS#:_____

OTHER INFORMATION: (for treatment or evaluation of conditions not covered above)

Was Injury Work Related?____☐____ Motor Vehicle Accident?____☐____ Date of Accident:_____

Name of Insurance Company:_____ Adjuster:_____

Address:_____

Tel#:_____Claim #:_____

ASSIGNMENT OF BENEFITS:

I hereby assign to Beverly Friedlander, MD all payments to which I am entitled for medical and/or surgical expenses for services rendered. I understand that I am financially responsible for all charges related to my treatment not covered by this assignment of benefits. I authorize the practice to release any personal and medical information necessary to process this claim.

_____ Date:_____
Signature

_____
Print Name(Guarantor if patient a minor)

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Notice of Privacy Practices:

The Health Insurance Portability and Accountability Act of 1996 (**HIPAA**; Pub.L. 104–191, 110 Stat. 1936, enacted August 21, 1996) was enacted by the United States Congress and signed by President Bill Clinton in 1996. The **HIPAA** Privacy Rule protects the privacy of individually identifiable health information and sets national standards for the security of electronic protected health information (**PHI**). Our full Patient Privacy Policy can be reviewed on our website(www.DoctorBev.com). A copy of this policy is available for your review in our office as well.

_____ _____

Signature Date

Authorization to Disclose Protected Health Information(PHI):

Protected health information (PHI) is information that may identify you and relates to your physical or mental health and related healthcare services. As required by **HIPAA**, Beverly Friedlander, MD ("**Practice**") has provided a Notice of Privacy Practices describing how it may use and disclose PHI. It is important to understand that any uses or disclosures outside those circumstances described in the notice will be made **only with your written authorization.** This means we will not disclose information to a person despite their relationship with you unless you have specifically authorized them to receive such information. Once disclosed, this information is no longer subject to protection under state and federal laws and may be re-disclosed by the recipient.

AUTHORIZATION:

I authorize the Practice to disclose my PHI to those individual(s) listed below:
Please identify name relationship and contact information.

_____

_____

Please identify any limitations on the disclosure of your PHI

_____

_____ _____ _____

Print name Signature Date

Authorization to be Contacted via Email:

I hereby request to be contacted through Email or alternate means. I understand that in the course of doing so, my protected health information (PHI) may be viewed by individuals I did not intend. I understand that I may revoke this request, in writing, at any time. Please describe below the specific means you would like employed, including alternate address, phone numbers, e-mail addresses, etc.

_____

_____

_____ _____ _____

Print Name Signature Date

BeverlyFriedlanderMD

Plastic Surgery and Med Spa

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No Show and Cancellation Policy

At Beverly Friedlander MD Plastic Surgery and TrueBeauty MedSpa, our goal is to provide quality care in a timely manner. We have implemented a no show and cancellation policy which enables us to better utilize available appointments for our patients.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

Please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone else. Available appointments are in high demand and your early cancellation will give another patient the opportunity to be seen in a timely manner.

- **Patients who fail to show for their scheduled appointment and do not notify the office within 1 business day or 24 hours of their scheduled appointment time or patients who call to reschedule with less than 1 business day or 24 hours' notice, shall be subject to a "No Show/Cancellation" fee of $100.**
- **Patients will be rescheduled no more than 3 times for repeat late cancellations or no show.**

- **Complimentary procedures in our Med Spa will not be rescheduled due to late cancellation or no show.**

_____ _____

Patient Printed Name Date

_____ _____

Patient/Guardian Signature Date