

# Beverly Friedlander MD

Plastic Surgery

636 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 Zip Code

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:

<input type="checkbox"/> Brow Lift	<input type="checkbox"/> Breast Augmentation	<input type="checkbox"/> Coolsculpting	<input type="checkbox"/> Brazilian Butt Lift
<input type="checkbox"/> Face Lift	<input type="checkbox"/> Breast Lift	<input type="checkbox"/> Liposuction	<input type="checkbox"/> Vaginoplasty
<input type="checkbox"/> Eyelid Surgery	<input type="checkbox"/> Breast Reduction	<input type="checkbox"/> TummyTuck	<input type="checkbox"/> Lasers
<input type="checkbox"/> Ear Surgery	<input type="checkbox"/> Mommy Makeover	<input type="checkbox"/> Other Body Contouring	<input type="checkbox"/> Brown Spots
<input type="checkbox"/> Fillers/Botox	<input type="checkbox"/> Breast Reconstruction	<input type="checkbox"/> Gynecomastia	<input type="checkbox"/> 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

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

Please Explain All:

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### REVIEW OF SYSTEMS:

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

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Weight Gain or Loss | <input type="checkbox"/> Lung                      | <input type="checkbox"/> Muscles/Bones       | <input type="checkbox"/> Thyroid                  |
| <input type="checkbox"/> Head                | <input type="checkbox"/> Heart                     | <input type="checkbox"/> Reproductive System | <input type="checkbox"/> Skin Diseases            |
| <input type="checkbox"/> Eyes                | <input type="checkbox"/> Blood Pressure or Vessels | <input type="checkbox"/> Kidney/Bladder      | <input type="checkbox"/> Swollen Glands/Lymph Nod |
| <input type="checkbox"/> Ears                | <input type="checkbox"/> Digestive System          | <input type="checkbox"/> Liver               | <input type="checkbox"/> Depression               |

Please Explain All:

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### 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 CURRENTLY 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.

\_\_\_\_\_  
Signature Date: \_\_\_\_\_

\_\_\_\_\_  
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](http://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