

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:

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:

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). 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