**Patient Registration**

Prefix__________ Name_________________________________________________________________

Nickname (If Any) ________________________ Personal Physician __________________________

How did you hear about our office?

- Referred by Physician. Which? _____________________________________
- Referred by Friend. Whom? _______________________________________
- Website. Which site? _____________________________________________

**Personal Information**

Address _____________________________________________________________________________
City, State, Zip ______________________________________________________________________
Social Security No ______-______-_____ Birthdate _____/______/______
Home Phone ____________________________ Work Phone______________________________
Cell Phone _____________________________ (for office use only)
Email Address __________________________ (for office use only)

Are you? ❑ Married ❑ Single ❑ Divorced/Separated ❑ Widowed

Gender ❑ Male ❑ Female ❑ Other: __________________________

Ethnicity ❑ Not Hispanic or Latino ❑ Hispanic or Latino (for office use only)

❑ Please check here to receive office newsletters, updates, and special offers via email

In Case of Emergency, Please Contact __________________________________________________
Relationship ____________________________ Phone Number _____________________________

Spouse's Name (if married) __________________________________________________________
Spouse's Employer ____________________________________________________________________
Work Phone ____________________________ Cell Phone ________________________________

**Insurance Information (Cosmetic Consult Patients Do Not Need to Fill Out)**

Name of Insured _______________________________ Relationship _________________________
Insured Address _____________________________________________________________________
Insured Employer ____________________________________________________________________
DOB of Insured ______/_____/_____ Social Security No _____-_____-_____
**Primary** Insurance Co _______________________________________________________________
Policy No _________________________________ Group No ______________________________
**Secondary** Insurance Co _____________________________________________________________
Policy No _________________________________ Group No ______________________________

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COLUMBIA AESTHETIC
PLASTIC SURGERY, LLC

## Patient Health History

Name ______________________________ Occupation ____________________
Age ____________ Height ____________ Weight ____________ Are you actively dieting? ____________
Reason for your visit today ______________________________________________
List your Significant Medical Problems
______________________________________________
______________________________________________
List your Previous Operations (Including Cosmetic Procedures)
______________________________________________
______________________________________________
______________________________________________
Are you allergic to any medications? What happened when you took these medications?
(Include reactions to tape, iodine, local anesthetics, etc.)
______________________________________________

Are you currently on any medications? (Include over-the-counter meds and supplements)

| Medication | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Do you take Aspirin, Motrin, or any Blood Thinners on a regular basis? ❑ YES ❑ NO
If YES, What for? ______________________________________________

Have you been on Steroids (Cortisone/Prednisone) in the last year? ❑ YES ❑ NO
IF YES, What for?______________________________________________

Are you a Smoker? (This includes: Vaping, Nicotine Patches and other nicotine products)
❑ YES ❑ NO - How much do you smoke or when did you quit? ____________________

How much do you drink? ❑ Never ❑ Occasionally ❑ Nightly (1-2 drinks) ❑ Frequently

Have you ever used Recreational Drugs? ❑ YES ❑ NO - If YES, Which? ______________

**(For Women Only)** Are you Pregnant? ❑ YES ❑ NO Are you Breastfeeding? ❑ YES ❑ NO

Are you under the care of a Psychiatrist or Psychologist? ❑ YES ❑ NO
If YES, what for? ______________________________________________

Are there any Cancers that run your family? ❑ YES ❑ NO
If YES, please explain. ______________________________________________

Is there a history of Heart Problems, Strokes, or Blood Clots in the Family? ❑ YES ❑ NO
If YES, please explain. ______________________________________________

Are there any other serious Medical Conditions that run in the Family? ❑ YES ❑ NO
If YES, please explain. ______________________________________________

Have you ever had Skin Cancer? ❑ YES ❑ NO
If YES, please explain. ______________________________________________

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COLUMBIA AESTHETIC
PLASTIC SURGERY, LLC

Do you have a history of any of the following conditions?

| Condition | YES | NO | If YES, please explain |
|---|---|---|---|
| Heart Murmur/Damaged Heart Valves? | | | |
| Do you take Antibiotics prior to dental work? | | | |
| High or Low Blood Pressure? | | | |
| Chest Pain/Angina? | | | |
| Heart Attack or Stroke? | | | |
| Irregular Heartbeat or Pacemaker? | | | |
| Asthma or Lung Disease? | | | |
| Tuberculosis? | | | |
| Shortness of Breath with Walking? | | | |
| Pain in the calves with Walking? | | | |
| Anemia or Blood Disorders? | | | |
| Bleeding Problems (Do you bruise easily)? | | | |
| Clotting Problems (DVT, Pulmonary Embolus)? | | | |
| Hepatitis or HIV? | | | |
| Liver or Kidney Disease? | | | |
| Seizures or Epilepsy? | | | |
| Thyroid Problems? | | | |
| Diabetes or Insulin pump? | | | |
| Stomach Ulcers? | | | |
| Fever blisters of the lips or Herpes? | | | |
| Immune system or healing problems? | | | |
| Mental Health Problems? | | | |
| Glaucoma or Eye disease? | | | |
| Do you wear Contact Lenses? | | | |
| Radiation Therapy or Chemotherapy? | | | |
| Blood transfusion? | | | |
| Family history of Malignant Hyperthermia? | | | |
| Do you form large scars or keloids? | | | |
| Sleep Apnea or CPAP Machine? | | | |

The above information is true to the best of my knowledge. I will not hold my surgeon or his office responsible for any errors or omissions that I may have made in completion of this form.

Signature ________________________________________ Date ___________________

**(For Office Use Only)** ☐ The above patient health history including past medical/surgical history, medications, allergies, family and social history and review of systems have been reviewed with the patient.
_______________________________ E. Chang, MD / Josephine Dubon, PA-C

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**Pharmacy Information**

**Our Office is trying to better serve our patients by electronically submitting prescriptions, please fill out the form below; please note that pain medication can't be electronically sent**

Patient Name: ______________________________________________________
Last First M.

Patient Phone Number: _______________________________________________

Date of Birth (MM/DD/YYYY): _____/_____/_____

Current
Pharmacy: _______________________________________
Pharmacy Name

Address: ________________________________________
________________________________________

Phone Number: ___________________________________

**Patient**
**Signature: ___________________________ Date: ________________________**

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## AUTHORIZATION TO RELEASE MEDICAL PHOTOGRAPHS

**This is a consent document that has been prepared to help inform you concerning permission to take photographs and to use these images for a purpose as defined within this consent. It is important that you read this information carefully and completely.**

I hereby authorize Eric Chang, M.D. and/or his staff to take photographs appropriate for my surgery and care.

I further authorize my doctor to use the photographs for professional medical purposes deemed appropriate including but not limited to showing the photos for medical education, patient education, lectures to medical or lay groups, or during office seminars.

I understand that I will not be entitled to any payment or other form of remuneration as a result of any use of the photographs or slides.

**My photographs may be selected for display in advertisements related to the practice.**

(Please Check One Box) ❑ YES ❑ NO

Signature ________________________________ Date ________________

Witness _________________________________ Date ________________

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## NOTICE OF PRIVACY PRACTICES

This Notice describes how medical/protected health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Summary: By law, we are required to provide you with our Notice of Privacy Practices. This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

- The right to inspect and copy your information
- The right to request corrections to your information
- The right to request that your information be restricted
- The right to request confidential communications
- The right to a report of disclosures of your information
- The right to a paper copy of this Notice

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will ensure that your information remains private.

We reserve the right to change our privacy practices as described in this Notice. If we change our practice, we will issue a revised Notice, which will contain the changes. Those changes may apply to any of your medical/protected health information that we maintain.

If you have any questions about this Notice, you may contact:

Effective Date of Notice: November 1, 2006
Mrs. Nicole Smiroldo, Columbia Aesthetic Plastic Surgery, LLC
8860 Columbia 100 Parkway, Suite 206
Columbia, MD 21045
Telephone 410-740-9330
Fax 410-740-9335

**I, _____________________________________, have had the full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.**

**Signature ___________________________________________ Date ____________________**
**(If signing as a parent/guardian) ___________________________________________________**
**(Name of Patient) (Relationship)**

**(FOR OFFICE USE ONLY)**

❑ **Patient refused to Sign**

❑ **Patient was unable to Sign because _________________________________**

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# FINANCIAL POLICIES

**Basic Policy** – Charges, deductibles, co-pays and/or coinsurances are due at the time of service.

**Surgery Fees** – All payments for non-covered surgical procedures are due prior to your surgery. Your carrier may require preauthorization. All anesthesia and laboratory fees will be billed directly to the patient.

**For Patients with Insurance** – We will bill your insurance carrier for you if we are a participating provider and if the proper paperwork is provided to us. Referrals (if required) must be obtained and brought to our office for initial consultations and follow-up visits. Co-payments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, office and surgery fees are due and payable in full from you.

**Medicare Patients** – We will bill Medicare for you. We will also bill secondary insurance for you. All co-payments or deductibles are due and payable at the time service is provided.

**Medicare Patients** – **Signature on File** – I request payment of authorized Medicare benefits be made either to me or on my behalf to Columbia Aesthetic Plastic Surgery LLC for any services furnished me by the listed provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services.

**Non-Covered Services – Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.**

**Worker’s Compensation** – We handle Worker’s Compensation/Personal Injury Cases on an emergency basis only.

**Missed Appointments** – In fairness to other patients and to our office, we require at least 24 hours notice to cancel appointments. You may be charged $30 for missed appointments or be dismissed from the practice.

**Cosmetic Patients (please read and sign below)**

I have Read, Understood, and Agreed to the above Financial Policy for payment of professional and surgery fees. The patient is ultimately responsible for all fees.

Signature ________________________________________ Date ___________________
Witness ________________________________________ Date ___________________

**Insurance Patients (please read and sign below)**

Assignment of Insurance Benefits - I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Columbia Aesthetic Plastic Surgery, LLC. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment (including photographs).

Signature ________________________________________ Date ___________________

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