

PATIENT REGISTRATION FORM

Welcome to Freed Plastic Surgery
In order to serve you properly, we will need the following information.

TODAY'S DATE _____

PATIENT'S NAME (last) _____ (first) _____ (m.i.) _____

IF CHILD, PARENTS NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____ (work / cell / emergency#) _____

BIRTHDATE _____ SEX _____ SOCIAL SECURITY # _____

OCCUPATION _____

WHAT IS YOUR CHIEF COMPLAINT/CONCERN? _____

WHOM MAY WE THANK FOR REFFERRING YOU? _____

***INSURANCE INFORMATION** (Non-cosmetic Procedures ONLY)

PATIENT STATUS:

Single Married Widowed Employed Retired Unemployed Full-time Student

PRIMARY INSURANCE _____ IDENTIFICATION# _____

PATIENT'S RELATIONSHIP TO INSURED: Self Spouse Child

Other _____

ADDRESS OF INSURED (if different from patient) _____

INSURED'S BIRTHDATE _____

SECONDARY COVERAGE _____ IDENTIFICATION# _____

***ALL HMO'S (health maintenance organizations) require prior-authorization from a primary care physician before being seen.**

PRIMARY CARE DOCTOR _____

I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION NECESSARY TO EXPEDITE INSURANCE CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES THAT ARE NOT COVERED BY MY INSURANCE COMPANY.

X _____ DATE _____

Signature of patient of parent if minor

PATIENT REGISTRATION FORM

PATIENT NAME _____ DATE OF BIRTH _____

Do you smoke? If so, the type and amount _____

If former smoker, date quit _____

Weight _____ Height _____

Drug Allergies _____

List previous surgeries or major illnesses and dates _____

List any medications you are taking. Including non-prescription drugs, vitamins and herbals

FAMILY HISTORY

Has any blood relative ever had the following?

High Blood Pressure.....	No	Yes	Melanoma.....	No	Yes	Stroke.....	No	Yes
Depression.....	No	Yes	Heart Disease.....	No	Yes	Kidney Disease.....	No	Yes

PAST MEDICAL HISTORY

Have you ever had the following?

Heart Disease.....	No	Yes	Cancer.....	No	Yes	Stomach Ulcer.....	No	Yes
Arthritis.....	No	Yes	Glaucoma.....	No	Yes	Kidney Disease.....	No	Yes
Rheumatic Fever.....	No	Yes	Asthma.....	No	Yes	Thyroid Disease.....	No	Yes
Anemia.....	No	Yes	AIDS or HIV+.....	No	Yes	Bleeding Tendency.....	No	Yes
Tuberculosis.....	No	Yes	Stroke.....	No	Yes	Mitral Valve Prolapse....	No	Yes
Diabetes.....	No	Yes	High Blood Pressure.....	No	Yes			
Hepatitis.....	No	Yes						

REVIEW OF SYSTEMS

Do you have now or have you had in the past year?

Weight Change.....	No	Yes	Joint or muscle pain.....	No	Yes	Chronic Cough.....	No	Yes
Dry Eyes.....	No	Yes	Swollen Lymph Nodes...	No	Yes	Jaundice.....	No	Yes
Skin Rash.....	No	Yes	Swollen Feet/Ankles.....	No	Yes	Easy Bleeding.....	No	Yes
Chronic Diarrhea.....	No	Yes	Rapid Heart Beat.....	No	Yes	Easy Bruising.....	No	Yes
Seizures.....	No	Yes	Depression.....	No	Yes	Chest Pain.....	No	Yes

Women Only

Approximate date of last mammogram _____ Number of pregnancies _____

Did you breast feed? _____ Breast lump or discharge noted? _____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X _____
Signature of patient or parent if minor

Date

FREED PLASTIC SURGERY MEDICAL CENTER

We have entered an age of extreme complexity in regard to the various insurance policies that each insurance company provides. Because of this, it has become necessary for our office to place the responsibility of understanding the requirements of your particular insurance policy on you. This includes, but is not limited to, knowing which facilities can be used for laboratory, hospitalization, or outpatient surgery. Also, it is critical that you notify our staff of any insurance changes you may have.

For surgical services, if the patient is responsible for co-payments, deductibles, non-covered services and/or amounts that insurance denies. If you have HMO insurance, we ask that you obtain a referral from your primary care physician before you schedule an appointment with our office. You may be held financially responsible if a referral/authorization is not obtained prior to your visit. Upon request, a payment arrangement may be discussed with our financial coordinator and reviewed for implementation.

After your consultation with Dr. Freed our Insurance Coordinator will contact your insurance company to determine if prior-authorization is required for the proposed procedure. **It can take up to 45 business days for your insurance company to process an authorization request.** Please do not schedule any further appointments or surgery prior to insurance approval.

Patients receiving cosmetic services must pay 10% down in order for our staff to schedule surgery. The remaining balance will be due 1-2 weeks prior to surgery.

After your cosmetic consultation with Dr. Freed our Patient Care Coordinator will send you a cost estimate along with a follow-up call to answer any questions or concerns that you may have.

Our staff is happy to assist you in any way that we can. However, if you are planning on utilizing your insurance company for any or all of the payment to Dr. Freed then please note that you are ultimately responsible for understanding your policy completely.

Please sign below stating that you understand this policy. Thank you for choosing Dr. Freed for your medical care. We are committed to providing the best possible care.

Patient Signature

Date

Printed Name