

**THE PLASTIC SURGERY GROUP, P.C.**  
**PATIENT REGISTRATION**

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ SEX(M) \_\_\_\_\_ (F) \_\_\_\_\_ M/S/D: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

TOWN: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PHONE#: \_\_\_\_\_ BUSINESS PHONE # \_\_\_\_\_

PATIENT'S AGE: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ PATIENT SS# \_\_\_\_\_

WHO REFERRED YOU TO OUR OFFICE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

FAMILY DOCTOR/PEDIATRICIAN: \_\_\_\_\_ PHONE #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

IN CASE OF EMERGENCY PLEASE NOTIFY: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ PHONE #: \_\_\_\_\_

PATIENT'S OR GUARDIAN'S EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE #: \_\_\_\_\_

REASON FOR VISIT: \_\_\_\_\_ DATE OF ONSET/ACCIDENT: \_\_\_\_\_

ACCIDENT DESCRIPTION: \_\_\_\_\_

HOW / WHERE INJURY OCCURRED: \_\_\_\_\_

WAS PATIENT INJURED ON THE JOB ? (YES) \_\_\_\_\_ (NO) \_\_\_\_\_ IN AN AUTO ACCIDENT?(YES) \_\_\_\_\_ ( NO) \_\_\_\_\_

**(IF ON THE JOB INJURY OR NO FAULT, PLEASE COMPLETE INFORMATION ON REVERSE SIDE)**

**INSURANCE # 1**

NAME OF INSURANCE CARRIER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

NAME OF POLICY HOLDER: _____	NAME OF EMPLOYER PROVIDING COVERAGE: _____
POLICY HOLDER'S SS# _____	POLICY HOLDER'S DATE OF BIRTH: _____ SEX: (M) _____ (F) _____
POLICY ID # : _____	GROUP#: _____ PLAN#: _____

**INSURANCE # 2**

NAME OF INSURANCE CARRIER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

NAME OF POLICY HOLDER: _____	NAME OF EMPLOYER PROVIDING COVERAGE: _____
POLICY HOLDER'S SS# _____	POLICY HOLDER'S DATE OF BIRTH: _____ SEX: (M) _____ (F) _____
POLICY ID # : _____	GROUP#: _____ PLAN#: _____

**IF YOUR INSURANCE REQUIRES A REFERRAL, IT IS YOUR RESPONSIBILITY TO FURNISH US WITH IT PRIOR TO SEEING THE DOCTOR. FAILURE TO DO SO WILL RESULT IN THE PATIENT BEING RESPONSIBLE FOR THE BILL.**

**THE PLASTIC SURGERY GROUP, P.C.**

**SELF-PAY:** (Must be completed if you have no insurance)

RESPONSIBLE PARTY'S NAME: \_\_\_\_\_ SS#: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

TOWN: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

I.D. RECEIVED: (to be completed by receptionist) \_\_\_\_\_

**FOR ON THE JOB INJURY:**

DATE OF ACCIDENT: \_\_\_\_\_ TIME: \_\_\_\_\_ AM PM TOWN WHERE ACCIDENT  
TOOK PLACE \_\_\_\_\_

DESCRIPTION OF ACCIDENT: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ SUPERVISOR: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

PHONE #: \_\_\_\_\_ CONTACT: \_\_\_\_\_

POLICY #: \_\_\_\_\_ CARRIER CASE #: \_\_\_\_\_ WCB CASE #: \_\_\_\_\_

ARE YOU STILL WORKING? (YES) \_\_\_\_\_ (NO) \_\_\_\_\_ LAST DATE WORKED: \_\_\_\_\_

**FOR AUTOMOBILE ACCIDENT:** (Please supply receptionist with copy of insurance ID card)

DATE OF ACCIDENT: \_\_\_\_\_ PATIENT WAS: DRIVER: \_\_\_\_\_ PASSENGER: \_\_\_\_\_ PEDESTRIAN: \_\_\_\_\_ WORKING AUTO \_\_\_\_\_

NAME OF POLICY HOLDER: \_\_\_\_\_ PHONE #: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

PHONE #: \_\_\_\_\_ CONTACT: \_\_\_\_\_

POLICY #: \_\_\_\_\_ FILE #: \_\_\_\_\_

**INSURANCE PAYMENT ORDER & AUTHORIZATION TO RELEASE INFORMATION:**

I HEREBY AUTHORIZE MY INSURANCE COMPANY(S) KNOWN BY THE NAME(S) OF \_\_\_\_\_  
TO PAY DIRECTLY TO THE PLASTIC SURGERY GROUP, P.C., BENEFITS DUE ME OUT OF INDEMNITY UNDER  
THE TERMS OF MY POLICY. PAYMENT IS AUTHORIZED UPON YOUR RECEIPT OF THEIR ITEMIZED BILL. THIS  
POLICY WAS IN FULL FORCE AND EFFECT AT THE TIME SERVICES WERE RENDERED. IN THE EVENT THAT WE  
HAVE TO REFER YOUR ACCOUNT FOR LEGAL ACTION, ANY AND ALL REASONABLE COLLECTION AND/ OR  
ATTORNEY FEES WILL BE ADDED TO THE PATIENT'S BILL.

I HEREBY AUTHORIZE THE PLASTIC SURGERY GROUP, P.C. TO FURNISH INFORMATION TO INSURANCE  
CARRIER AND/ OR EMPLOYERS CONCERNING ILLNESS AND TREATMENT RECEIVED BY ME FOR THE PURPOSE  
OF PROCESSING MY CLAIM(S) FOR MEDICAL SERVICE:

INSURED NAME : \_\_\_\_\_

LEGAL SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

650 NORTHERN BLVD  
GREAT NECK NY 11021  
(516) 466-7000  
(516) 466-9025 FAX

242 MERRICK RD  
SUITE 302  
ROCKVILLE CENTRE NY 11570  
(516) 536-5858  
(516) 536-6119 FAX

## THE PLASTIC SURGERY GROUP, P.C.

GREGORY A. DEVITA, M.D., F.A.C.S.  
ANTONIO L. URIA, M.D., F.A.C.S.

MARTIN E. KESSLER, M.D., F.A.C.S.  
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### MEDICAL HISTORY FORM

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

#### PAST MEDICAL HISTORY:

General Health :    Good \_\_\_\_\_    Fair \_\_\_\_\_    Poor \_\_\_\_\_

If not "Good", please explain :

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HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ WEIGHT LOSS: \_\_\_\_\_ GAIN: \_\_\_\_\_ IN PAST YEAR: \_\_\_\_\_ lbs.

HOW LONG AGO WAS YOUR MOST RECENT CHECK-UP? \_\_\_\_\_

NAME & ADDRESS OF YOUR DOCTOR: \_\_\_\_\_

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#### PREVIOUS SURGERY (Please list)

Operation	Year	Hospital	Doctor	Local or General Anesthesia?
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PREVIOUS ILLNESSES (Please List): \_\_\_\_\_

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ARE YOU CURRENTLY BEING TREATED FOR ANY ILLNESS OR CONDITIONS? If so, please list:

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ARE YOU ALLERGIC TO ANY MEDICATIONS? YES \_\_\_\_\_ NO \_\_\_\_\_ if yes, Please list:

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Continued on back

**CURRENT MEDICATIONS** (Please list all medications you are now taking and their dosages, including birth control pills, diuretics or water pills, blood pressure or heart medication, pain medications, or any other prescribed or over the counter medications): \_\_\_\_\_

**WHAT IS YOUR APPROXIMATE DAILY CONSUMPTION OF THE FOLLOWING:**

COFFEE OR TEA: \_\_\_\_\_ TOBACCO: \_\_\_\_\_ ALCOHOL: \_\_\_\_\_

OTHER INTOXICATING OR MIND ALTERING DRUGS ( SPECIFY): \_\_\_\_\_

**PERTINENT PRE-OPERATIVE INFORMATION:**

Have you ever reacted badly to being put to sleep for surgery? No \_\_\_\_ Yes \_\_\_\_

Has any member of your family ever reacted badly to being put to sleep for surgery? No \_\_\_\_ Yes \_\_\_\_

Have you required large amounts of anesthetic for medical or dental procedure? No \_\_\_\_ Yes \_\_\_\_

Have you ever had a bad reaction to local anesthetic( Novacain, etc?) No \_\_\_\_ Yes \_\_\_\_

Are you allergic to adhesive tape? No \_\_\_\_ Yes \_\_\_\_

Are you allergic to suture material? No \_\_\_\_ Yes \_\_\_\_

Have you ever had Scarlet fever or Rheumatic Fever? No \_\_\_\_ Yes \_\_\_\_

Do you have high blood pressure? No \_\_\_\_ Yes \_\_\_\_

Do you bleed unusually easily (from cuts, surgery, tooth extractions, etc)? No \_\_\_\_ Yes \_\_\_\_

Do you bruise easily? No \_\_\_\_ Yes \_\_\_\_

Have you ever had a transfusion for surgery? No \_\_\_\_ Yes \_\_\_\_

Are you a slow or poor healer? No \_\_\_\_ Yes \_\_\_\_

Do you form large scars or keloids? No \_\_\_\_ Yes \_\_\_\_

Have you ever taken steroid medications, cortisone, or ACTH? No \_\_\_\_ Yes \_\_\_\_

Do you have shortness of breath with walking? No \_\_\_\_ Yes \_\_\_\_

Do you have or have you had significant emotional problems? No \_\_\_\_ Yes \_\_\_\_

Are you pregnant? No \_\_\_\_ Yes \_\_\_\_

**FAMILY HISTORY:**

Give age and State of Health for each:

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Brother(s) \_\_\_\_\_

Sister(s) \_\_\_\_\_

Children: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**HAS ANY RELATIVE HAD:**

Tuberculosis: No \_\_\_\_ Yes \_\_\_\_

Cancer: No \_\_\_\_ Yes \_\_\_\_

Diabetes: No \_\_\_\_ Yes \_\_\_\_

Epilepsy: No \_\_\_\_ Yes \_\_\_\_

Heart Disease: No \_\_\_\_ Yes \_\_\_\_

High Blood Pressure: No \_\_\_\_ Yes \_\_\_\_

Blood or Bleeding Disorders: No \_\_\_\_ Yes \_\_\_\_

Asthma or Lung Disease No \_\_\_\_ Yes \_\_\_\_

**Signature of patient** or other: \_\_\_\_\_ Date: \_\_\_\_\_

(If "other" please indicate relation): \_\_\_\_\_

## **HIPAA PRIVACY NOTICE**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Effective April 14, 2003

The Privacy of your medical information is important to us. You may be aware that U.S. government regulators established a privacy rule ("HIPAA") governing protected health information. This notice tells you about how it may be used, and about certain rights that you have.

Harriet Piltz, Administrator is in charge of privacy matters at our office. You can contact her at (516) 466-7000 if you desire further information, or have any questions or concerns.

### **Use and disclosure of protected information.**

Federal law provides that we may use your medical information (protected health information) for treatment of you, without further specific notice to you, or written authorization by you. Example, if we refer you to a specialist, we may provide laboratory or test data to that specialist (subject to more stringent New York Laws, such as restriction on disclosures of information concerning HIV/AIDS")

Federal law provides that we may use your medical information to obtain payment for our services without further specific notice to you, or written authorization by you. Example, under your health plan, we are required to provide then with diagnosis code for your visit and a description of the services rendered.

Federal law provides that we may use your medical information for health care operations without further specific notice to you. Or written authorization by you. Example, our accountant may see your name, dates of treatment and procedure codes during audits of our books : we may use your information for financial services, quality assurance, risk reduction and claim management purposes with our medical professional liability insurer.

We May use or disclose your medical information, without further notice to you, or specific authorization by you, where:

1. required by the law
2. required for public health purposes;
3. required by the law to report child abuse;
4. where required by the health oversight agency for oversight activities authorized by law, such as Department of Health Office of professional Discipline or Office of Professional Medical Conduct.
5. required by law in judicial or administrative proceedings;
6. required by law enforcement purposes by law enforcement official;
7. required by a coroner or medical examiner;
8. permitted by law to a funeral director;
9. permitted by the law for organ donation purposes;
10. permitted by law to avert a serious threat to health or safety;
11. permitted by law and required by military authorities if you are a member of armed forces of United States;
12. [research purposes(if applicable to our practice, see details at 45 CFR & 164.512(1))]

New York States law provides additional protection for information regarding HIV/AIDS. We will continue to follow New York State Law with respect to such information.

We may contact you by mail or phone, at you residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make reasonable request, in writing , for us to use alternative methods of communicating with you in a confidential manner.

Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

**Rights that you have.**

You have the right to request restrictions on certain of the uses or disclosures described above. Except as stated below, we are not required to agree such restriction .

You have the right to inspect and obtain copies of your medical information ( a reasonable fee will be charged).

You have the right to request amendments to your medical information,. Such request must be in writing , and must state the reason for the requested amendment. We will notify you as to whether we agree to disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosures we make of your medical information, except for: disclosures we make to you , or to carry out treatment, payment or health care operations, or as requested by your written authorization, or as permitted or required under 45 CFR & 164.502, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law [ or for research or public disclosure made before April 14,2003.

If you have received this notice electronically, you have the right to obtain a paper copy from our office.

**Obligations that we have**

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices.

We are required to abide by the terms of this notice as long as it is currently in effect.

We reserve the right to revise this notice, and to make new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available there.

If you want to complain about violations of your privacy rights, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file complaint with us. Complaint should go directly to Harriet Piltz, Administrator at 650 northern Boulevard great Neck NY 11021.

No retaliatory action will be taken against you for any complaint you may make.

I wish to designate the following person(s) to be able to speak on my behalf and have access to my Protected Health Information:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

### PRIVACY NOTICE ACKNOWLEDGMENT

I acknowledge that I have been provided with a copy of **The Plastic Surgery Group, P.C.**'s privacy notice.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

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### AUTHORIZATION FOR THE TAKING AND RELEASE OF PHOTOS

I, the undersigned patient, hereby consent to allow the doctors of **The Plastic Surgery Group, P.C.** to take, and/or release clinical photographs of me. I understand that these images may be used for any or all of the following purposes.

My surgical planning  
Resolution of my insurance claim(s)  
Patient and/or public education  
Marketing / Promotional (including website)

If I have any exceptions to the above they are listed as follows:

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With the exception of any particular items indicated by me on this form, I consent to the above stated of said photographs.

Signature \_\_\_\_\_

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

Witness: \_\_\_\_\_

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