BeverlyFriedlanderMD
Plastic Surgery
t: 973-912-9120 Contact@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 ZipCode

Name Of Responsible Party (If Other Than Patient)_____Relationship_____

Emergency Contact_____

Relationship_____ Phone(____)_____

How Did You Hear About Our Office? Referred By: _____ Google _____ Dr. Bev Website _____ Realself

_____ Facebook _____ Instagram

Please List Name If Referred by Friend / Employee / Current Patient / Other:_____

Primary Reason For Consultation:_____

Are you Interested in any of the following:

__Brow Lift	__Breast Augmentation	__Brazilian Butt Lift	__Morpheus	__Labiaplasty
__Face Lift	__Breast Lift	__Liposuction	__Fat Reduction	__Lasers
__Eyelid Surgery	__Breast Reduction	__Tummy Tuck	__Muscle Tone	__Brown Spots
__Ear Surgery	__Mommy Makeover	__Coolsculpting	__Skin Tightening	__Red Spots
__Fillers/Botox	__Gynecomastia	__Emsculpt	__Cellulite	__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

__Heart Disease	__Shortness of Breath	__Eye Disorder/Glaucoma	__ Diabetes/Pre Diabetes
__High Cholesterol	__Asthma	__Seizures/Stroke	__Thyroid
__High Blood Pressure	__Lung Problems	__Headaches/Migraines	__Hepatitis/ Liver
__Reflux/Ulcer	__Sinus Problems	__Neurological Problems	__ Arthritis
__Anemia/Blood Problems	__Seasonal Allergies	__Depression/Anxiety	__Muscle/Bones
__Swollen Ankles	__Ear Problems	__Psychiatric Care	__Colitis
__Vascular (Blood Vessels)	__Reproductive Organs	__Auto-Immune Disorder	__Scars/Skin

Please Explain All:

_____

_____

REVIEW OF SYSTEMS:

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

__Weight Gain or Loss	__Lung	__ Muscles/Bones	__Thyroid
__Head	__Heart	__Reproductive System	__Skin Diseases
__Eyes	__Blood Pressure or Vessels	__Kidney/Bladder	__Swollen Glands/Lymph Nod
__Ears	__Digestive System	__Liver	__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 CURRENTLT 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?_____ Bra Size: _____

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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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

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No Show and Cancellation Policy

At Beverly Friedlander MD Plastic Surgery 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 24 hours (1 Business Day) of their scheduled appointment time or patients who call to reschedule with less than 24 hours' notice, shall be subject to a "No Show/ Cancellation" fee of $250.**
- **Patients will be rescheduled no more than 3 times for late cancellations or no show.**

_____ _____

_ Patient Printed Name _ Date

_____ _____

_ Patient/Guardian Signature _ Date