



Mr./Mrs./Miss/Ms./Dr. _____

First Name Middle Last Name Nickname (if used)
STATUS: Single Married Divorced Widow

Street Address City/State Zip Code

Home Telephone Number Business Telephone No. Cellular Telephone No.

Social Security No. Date of Birth Age Email Address

Please initial here to allow us to contact you by email _____

Employer Street Address City/State Zip Code

REASON FOR VISIT: REFERRED BY:
Have you seen other plastic surgeons concerning the SAME problem that brings you here?

INSURANCE INFO: Worker's Compensation Motor Vehicle Accident Other

Name of Insurance Company Subscriber Relationship to Patient Policy No./Group No.

ACKNOWLEDGEMENT: I hereby acknowledge that in consideration for treatment rendered to me and/or my child or child in my care that I am responsible and will pay for all charges and fees of Elan B. Singer, MD for the services rendered. I understand that although I may have insurance to cover the cost of treatment, I remain responsible for payment. All payments are due within (30) days of receipt of the bill.
Signature (Patient or Responsible Party) Date
AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS: I hereby authorize Elan B. Singer, MD to release any information acquired in the course of my examination or treatment and further authorize payment of the surgical and/or medical benefits directly to Elan B. Singer, MD.
Signature (Patient or Responsible Party) Date
AUTHORIZATION TO PHOTOGRAPH: I hereby grant authority to Elan B. Singer, MD to take or have taken any necessary photographs of the patient whose name appears.
Signature (Patient or Responsible Party) Date



Height _____ Weight _____

ALLERGIES:

| Medications | Type of Reaction | Food | Type of Reaction | Environmental | Type of Reaction |
|-------------|------------------|------|------------------|---------------|------------------|
| | | | | | |
| | | | | | |
| | | | | | |

MEDICATIONS: (include aspirin, hormone replacement, birth control, diet pills, sleep aids, all vitamins, herbs, teas, over-the-counter or alternative therapies)

| Medication (name of drug) | Dosage (how much) | Frequency (how often) |
|---------------------------|-------------------|-----------------------|
| | | |
| | | |
| | | |
| | | |
| | | |

PAST MEDICAL HISTORY: Do you now or have you had in the past any of the following:

| | YES | NO | | YES | NO |
|----------------------|-----|-----|---------------------------------|-----|-----|
| Bleeding | ___ | ___ | Asthma | ___ | ___ |
| Chronic cough | ___ | ___ | Heart disease | ___ | ___ |
| High blood pressure | ___ | ___ | Tuberculosis | ___ | ___ |
| Jaundice | ___ | ___ | GI disease | ___ | ___ |
| Hepatitis | ___ | ___ | Fever blisters | ___ | ___ |
| Neurological disease | ___ | ___ | Lung disease | ___ | ___ |
| Steroid use | ___ | ___ | Convulsions | ___ | ___ |
| Kidney disease | ___ | ___ | Blood clots | ___ | ___ |
| Diabetes | ___ | ___ | Family history of blood clots | ___ | ___ |
| Rheumatic fever | ___ | ___ | Skin rashes | ___ | ___ |
| Heavy scars | ___ | ___ | Psychiatric/emotional disorders | ___ | ___ |

If “yes” to any of the above, please provide details:

LIST OTHER MEDICAL CONDITIONS: _____



PLASTIC SURGERY

PAST SURGERIES/HOSPITALIZATIONS:

| Date | Type of Surgery/Medical Problem | Name of Hospital | Doctor |
|------|---------------------------------|------------------|--------|
| | | | |
| | | | |
| | | | |

ANESTHESIA HISTORY:

Have you ever had a reaction to a general anesthetic? (being put to sleep) Yes No

Has a family member ever had a reaction to a general anesthetic? Yes No

Have you ever had a reaction to a local anesthetic (Novocain, etc.) Yes No

If “yes” to any of the above, please provide details:

SOCIAL HISTORY:

Tobacco (list type, amount/day and number of years) _____

If you ever smoked but don’t now, when did you quit? _____

Have you been exposed to heavy second hand cigarette, cigar or pipe smoke for an extended period of time on a regular basis in the past two years? _____

Do you use recreational drugs? _____

If yes, type of drug and number of years _____

Alcohol (type, how often) _____

FAMILY HISTORY: (list age, medical problem and if living or deceased)

| Mother | Father | Sisters | Brothers |
|--------|--------|---------|----------|
| | | | |
| | | | |
| | | | |

Primary Care MD:

Emergency contact person:

Name & Telephone No.

Name & Telephone No.

PATIENT/GUARDIAN SIGNATURE: _____

RELATIONSHIP OF GUARDIAN TO PATIENT: _____



COSMETIC INTEREST QUESTIONNAIRE

Our practice is constantly striving to offer you the safest, most advanced procedures for facial rejuvenation and overall physical improvement. Please check any of the following health issues you would like to receive more information on, either a brochure or consultation.

- Fine lines and wrinkles
- Facial Fillers
- Eyelashes; Longer, Fuller, Darker
- MicroDermabrasion
- Overall Skin Rejuvenation/Skin care advice
- Medical skin care products/Retin-A or Renova
- Treatment for spider veins/leg veins/facial veins
- Laser skin resurfacing
- Laser treatments with no downtime
- Laser hair removal
- Age spots/facial pigmentation problems
- OTHER_____
- Breast Augmentation (enlargement)
- Breast Reduction
- Breast Lift
- Liposuction
- Tummy Tuck
- Nose Surgery (rhinoplasty)
- Eyelid Surgery (blepharoplasty)
- Facelift
- Forehead/Brow Lift
- Chin Surgery
- Cheek Implants

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number:

- ◆ When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of wrinkles on my face.

| | | |
|----------------------|---------------------------|-----------------------|
| Not Concerned | Somewhat Concerned | Very Concerned |
| 1 | 2 | 3 |
| 4 | 5 | |

- ◆ When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my body.

| | | |
|----------------------|---------------------------|-----------------------|
| Not Concerned | Somewhat Concerned | Very Concerned |
| 1 | 2 | 3 |
| 4 | 5 | |



In order to clarify our office policy, we ask that you read and sign the following explanation.

Thank you.

Elan B. Singer, MD, PC has advised me that the practice only participates with a small number of insurance carriers at this time (Medicare, Oxford, United Healthcare). I understand that if my insurance carrier is different from the ones listed above, then this means they do not accept my insurance as payment in full.

I understand that I am responsible for any charges incurred and will be balance billed for all co-payments, non-covered charges over “usual and customary” and deductibles.

X _____
Patient/Guardian Signature

Date

X _____
Print Name



**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY
PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices for Elan B. Singer,
MD, PC.

Print Patient Name: _____

Signature of Patient: _____

Date: _____

If person signing is not the patient, please print your name and relationship to patient:

Name: _____

Relationship: _____



Assignment of Benefits

In consideration of services rendered, I hereby assign to the provider of services and/or his assignee benefits be made on my behalf to the provider, I understand that I am financially responsible for any balance not covered by my insurance carrier. I also understand that I will be responsible and agree to pay attorney's fees which is equal to 1/3 of the total balance plus any processing fees that might be incurred to collect payment in full. I authorize release of medical information to my insurer when needed to determine benefits payable.

Patient/responsible party signature: _____
Date