Welcome To Our Office

PATIENT REGISTRATION FORM

Sheldon S. Kabaker, M.D., Inc — *Aesthetic Facial Plastic Surgery Medical Clinic*

Please tell us how you heard about us or who referred you:_____

Name:_____ **Birthdate**:_____

Address:_____ **Apt#**_____

City:_____ **State**:_____ **Zip Code**_____

Home #:_____ **Work #**:_____

Cell Phone #:_____ **What # is best to reach you at?**_____

Social Security#_____ **Marital Status: S M D W**

Employer:_____ **Occupation**:_____

Email Address:_____

Emergency Contact:_____ Relationship:_____ Phone#_____

Health Insurance Information (if applicable)_____

Do You have an Advanced Healthcare Directive? Yes No (please circle one)

Please note: Patients with advance directives indicating a Do Not Rescessitate or "DNR", it is the policy of our facility, this will not be honored._____**Patient's please initial**

MEDICAL HISTORY

1. Are you **ALLERGIC** to any **MEDICATION** (please list)_____
_____

2. List ANY serious illnesses you have had and approximate date:_____
_____

3. List ALL MEDICATIONS you are currently taking:_____
_____

4. List ALL previous SURGERY you have had:_____
_____

5. Are you CURRENTLY under the care of ANY physician? YES NO (please circle one)

   If yes, for what condition:_____
   Name of Physician:_____

Signature of Patient:_____ **Date**:_____

Signature authorizes our physicians to see you as a patient

Sheldon S. Kabaker, M.D., Inc
Aesthetic Facial Plastic Medical Clinic

Medical History Questionnaire

Are you under a doctor's care? _____
Are you taking any medication? _____
Do you have any illness: _____
Do you take aspirin ? _____
Are you pregnant? _____
Face Marks/Discolorations: _____

Medical History: Have you had, or do you currently have any of the following, if so, please explain. (circle one)

Cosmetic Surgery	NO	YES	_____
Blood Transfusion	NO	YES	_____
Allergies	NO	YES	_____
Diabetes	NO	YES	_____
Hepatitis	NO	YES	_____
Heart Condition	NO	YES	_____
Hemophiliac Condition	NO	YES	_____
Skin Disorders	NO	YES	_____
Wear Contact Lenses	NO	YES	_____
Keloid Formation	NO	YES	_____
Local Anesthesia	NO	YES	_____

I certify that all the above information contributed by me is accurate to the best of my knowledge.

Signature: _____ Date: _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information *(PHI)*. The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

☐ Other _____

_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T=Treatment Records: P=Payment Information; O=Healthcare Operations
(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

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PRIVACY PRACTICES ACKNOWLEDGEMENT

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ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name:_____ Birthdate:_____

Signature _____

Date:_____