South Shore Cosmetic Surgeons, LLC

Patient Information as of _____ (enter todays date)

Patients Name _____
Last First Middle

Address: _____
Street & Apt # City State Zip Code

Home Phone: _____ **Cell Phone:** _____ **Other Phone:** _____

Any restrictions for contacting you? ❑ Yes ❑ No **E-Mail:** _____

Contact Restrictions: _____ **Referred By:** _____

Age _____ **Birthday** _____ **Sex:** ❑ Female ❑ Male

Marital Status: ❑ Single ❑ Married to: _____ ❑ **Other:** _____

Patient's Employer _____ **Occupation** _____
(Write Student if patient is in school and unemployed)

Work Phone: _____ **Ext:** _____ Is it okay to call you at work? ❑ Yes ❑ No

Address: _____
Street & Apt # City State Zip Code

Emergency Contact _____ **Relationship to Patient**_____

Home Phone: _____ **Cell Phone:** _____ **Other Phone:** _____

Primary Health Insurance Company _____

Insured Name: _____ **Insured Date of Birth:** _____
(Name of person the policy is under) (Policy holders date of birth)

Policy/ ID #: _____ **Group #:** _____ **Employer:** _____

Referral Required? ❑ Yes ❑ No **Copay?** ❑ Yes ❑ No
If yes, how much? $ _____

Secondary Health Insurance Company _____

Insured Name: _____ **Insured Date of Birth:** _____
(Name of person the policy is under) (Policy holders date of birth)

Policy/ ID #: _____ **Group #:** _____ **Employer:** _____

Referral Required? ❑ Yes ❑ No Copay? ❑ Yes ❑ No
If yes, how much? $_____

I authorize **South Shore Cosmetic Surgeons, LLC** to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between **South Shore Cosmetic Surgeons, LLC** and myself. I authorize the release of any medical information necessary to process claims and payment from my insurance company to be made directly to **South Shore Cosmetic Surgeons, LLC**. Office visits for self-paying patients are to be paid the day the service is rendered to me. **** Medicare patients are responsible for the difference between Medicare's reimbursement and Medicare's approved fee (which is about 20% of the fee), as well as non-approved fees. ****

Signature _____ **Date:** _____
(parent or guardian signature, if patient is a minor)

Name of Person Signing _____ **Date:** _____

SOUTH SHORE COSMETIC SURGEONS- HEALTH QUESTIONNAIRE

Name: _____ Referred By: _____

Family Physician & Location: _____

Reason(s) for seeing Doctor today: 1) _____ 3) _____

2) _____ 4) _____

List all medications you are taking: 1) _____ 3) _____

2) _____ 4) _____

Pharmacy Name: _____ Location: _____ Pharmacy Phone #: _____

ALLERGIES:

	Yes	No
Penicillin	❑	❑
Iodine	❑	❑
Codeine	❑	❑
Other	❑	❑

If so, please list: _____

DESCRIBE REACTION: _____

Weight Loss: _____ **Weight Gain:** _____

Have you taken any aspirin in the last two weeks? ❑ Yes ❑ No

Smoke: ❑ Yes ❑ No **If yes, how much?** _____

Drink: ❑ Yes ❑ No **If yes, how much?** _____

List all hospitalizations, operations (including plastic surgery) and serious injuries within the last 10 years:

Year	Hospitalization-Operation/Injury	Hospital & Location
_____	_____	_____
_____	_____	_____
_____	_____	_____

ILLNESS & MEDICAL PROBLEMS

	Yes	No		Yes	No		Yes	No
Dizzy Spells	❑	❑	Pneumonia	❑	❑	Stomach Ulcer	❑	❑
Glaucoma	❑	❑	Tuberculosis	❑	❑	Colitis	❑	❑
Eye Problems	❑	❑	Lung Problems	❑	❑	Diverticulosis	❑	❑
Ear Trouble	❑	❑	High Blood Pressure	❑	❑	Bowl Problems	❑	❑
Sinus Trouble	❑	❑	Heart Attack	❑	❑	Hepatitis _____	❑	❑
Diabetes	❑	❑	Hearing Problems	❑	❑	Mononucleosis	❑	❑
Heart Murmur	❑	❑	Heart Disease	❑	❑	Gall Bladder Trouble	❑	❑
Constant Nose Bleeds	❑	❑	Bleeding Disorder	❑	❑	Stroke	❑	❑
Chronic Nose Blockage	❑	❑	Anemia	❑	❑	Convulsion/ Seizures	❑	❑
Swelling in Neck	❑	❑	Bleed Easily	❑	❑	Scarlet Fever	❑	❑
Asthma	❑	❑	Bruise Easily	❑	❑	Bronchitis	❑	❑
Ankles Swell	❑	❑	Cancer _____	❑	❑	Other_____	❑	❑

FAMILY HISTORY

	Yes	No		Yes	No
Tuberculosis	❑	❑	Diabetes	❑	❑
Asthma	❑	❑	Rheumatoid Arthritis	❑	❑
Glaucoma	❑	❑	Heart Disease	❑	❑
High Blood Pressure	❑	❑	Low Blood Pressure	❑	❑
Arthritis	❑	❑	Bleeding Tendency	❑	❑
Trouble with Anesthesia	❑	❑	Paralysis	❑	❑
Blood Disorders (Sickle Cell Anemia, etc.)	❑	❑	Cancer	❑	❑

Family History of Cancer

Year	Type of Cancer	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

WOMEN ONLY

	Yes	No		Yes	No	
Tender Breasts	❑	❑	Fibrocystic Disease	❑	❑	Age at 1st Pregnancy? _____
Discharge from Nipples	❑	❑	Previous Mammogram	❑	❑	Year _____
Lumps in Breast	❑	❑	Change in Breast Size	❑	❑	Other Problems: _____
Menstrual Problems	❑	❑	Did/do you breast feed	❑	❑	_____

ACKNOWLEDGE STATEMENT

I understand that the services I receive from **South Shore Cosmetic Surgeons** may not be covered under my insurance plan. I understand that my insurance company determines the medical necessity of the services that I request and receive. I am also responsible for the deductibles, co-pays, non-covered services and items considered not "medically necessary" by my insurance company. I understand that I must inform this office of any change in my insurance coverage before services are rendered to me. Failure to inform the office will result in me being held responsible for all fees for the services rendered. I understand that if my plan required a referral, it is my responsibility to contact **South Shore Cosmetic Surgeons** at least 48 hours prior to the specialist appointment for non-urgent visits.

If you do not have any medical health insurance you will be held responsible for 100% of the fee for the services rendered to you. Payment is due in its entirety at the time of your visit.

_____

Signature of Patient or Legal Guardian

_____

Date

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, **South Shore Cosmetic Surgeons, LLC** may use and disclose protected and healthcare information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operation such as assessing quality and reviewing the competence of healthcare professionals.

Please refer to the **South Shore Cosmetic Surgeons** Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent and my signature indicates I have reviewed it or I have declined to review it prior to signing.

South Shore Cosmetic Surgeons reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **South Shore Cosmetic Surgeons**, 36 Lincoln Ave., Rockville Centre, NY 11570.

With my consent, **South Shore Cosmetic Surgeons** may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. With my consent, **South Shore Cosmetic Surgeons** may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment cards, patient statements, or forms.

I have the right to request that **South Shore Cosmetic Surgeons** restrict how it uses or discloses my PHI to carry TPO. However, the practice is not required to agree to my requested restrictions, but if it does, in writing, it is bound by this agreement.

By signing this form, I am consenting to **South Shore Cosmetic Surgeons** use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **South Shore Cosmetic Surgeons** may decline to provide treatment to me.

If I were to sign a Photo Release Consent (which I'd receive at a later date), I will agree to allow **South Shore Cosmetic Surgeons** to use my pre and post treatment photographs within its practice to educate future patients as long as I am not identified by face or name. If I decide I do not want my photographs to be used, I will not sign a Photo Release Consent.

_____ _____

Signature of Patient or Legal Guardian Print Name of Patient or Legal Guardian

_____

Date

South Shore Cosmetic Surgeons, LLC
36 Lincoln Ave.
Rockville Centre, NY 11570

Assignment of Benefits Form

Name of Insured (print): _____

I authorize Dr. Hassan/Dr. Waheed to submit to my insurance company on my behalf, and that **MY INSURANCE COMPANY PAY BENEFITS DIRECTLY TO DR. HASSAN/DR. WAHEED.** I authorized the release of any medical or other information necessary to determine these benefits or the benefits payable for related services to Dr. Hassan/Dr. Waheed.

Name of person signing below (print):_____

Relationship to Insured:_____

Signature of Insured or Parent/ Guardian: _____

Date: _____

Regardless of my insurance coverage, I am responsible for all bills being paid in a timely manner. I understand my contract is between South Shore Cosmetic Surgeons, LLC and myself. I also understand South Shore Cosmetic Surgeons may not participate in my insurance plan and payment might be directly sent to me, the insured. In this case, I also understand it is my responsibility to forward this payment to South Shore Cosmetic Surgeons, LLC.

Name of person signing below (print):_____

Relationship to Insured:_____

Signature of Insured or Parent/ Guardian: _____

Date: _____