

South Shore Cosmetic Surgeons, LLC

Patient Information as of _____ (enter today's 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 _____ SS #: _____ Sex: Female Male

Marital Status: Single Married to: _____ Other: _____

Emergency Contact _____ Relationship to Patient _____

(Not in your household, if patient is a minor, list parental information)

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

Assignment of Benefits Form

Name of Insured Company (print): _____

I authorize Dr. Hassan/Dr. Waheed to submit to my worker's compensation insurance company on my behalf, and that **MY NO FAULT 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.

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

Date: _____

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	DESCRIBE REACTION: _____
Penicillin	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Iodine	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Weight Loss: _____ Weight Gain: _____
Codeine	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you taken any aspirin in the last two weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No
Other	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
If so, please list:		Smoke: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much? _____
_____		Drink: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much? _____

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

<u>Year</u>	<u>Hospitalization-Operation/Injury</u>	<u>Hospital & Location</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

ILLNESS & MEDICAL PROBLEMS

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

FAMILY HISTORY

	Yes No		Yes No													
Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Diabetes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p style="text-align: center;">Family History of Cancer</p> <table border="0" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; width: 15%;">Year</th> <th style="text-align: center; width: 45%;">Type of Cancer</th> <th style="text-align: center; width: 40%;">Relationship</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Year	Type of Cancer	Relationship	_____	_____	_____	_____	_____	_____	_____	_____	_____
Year	Type of Cancer	Relationship														
_____	_____	_____														
_____	_____	_____														
_____	_____	_____														
Asthma	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>													
Glaucoma	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Heart Disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>													
High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>													
Arthritis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Bleeding Tendency	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>													
Trouble with Anesthesia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Paralysis	<input type="checkbox"/> <input type="checkbox"/>													
Blood Disorders <small>(Sickle Cell Anemia, etc.)</small>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Cancer	<input type="checkbox"/> <input type="checkbox"/>													

WOMEN ONLY

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

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 of Legal Guardian

Print Name of Patient of Legal Guardian

Date

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

Policy Holder: _____

Insurance Company: _____

Policy #: _____

Claim #: _____

Social Security #: _____

Date of Accident: _____

Brief Description of Accident: _____

Describe your Injury: _____

Name of Hospital you were treated in? _____

Identity of Vehicle you occupied or operated at the time of the accident:

Owner's Name

Make

Model

Year

The vehicle was: A bus or school bus Automobile (car/truck) A Motorcycle

Were you the driver of the Motor Vehicle? Yes No

Were you a passenger in the Motor Vehicle? Yes No

Were you a pedestrian? Yes No

Were you a member of the policyholder's household? Yes No

I certify the information I've provided you with above is true and correct to the best of my knowledge. Should I receive any more information regarding this claim, I will provide you with it in a timely fashion.

(Signature of Patient or Patient Representative)

Date