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** __________________ **SS #:** __________________ **Sex:** ❑ Female ❑ Male

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

Emergency Contact ______________________________ **Relationship to Patient** _____________________

(Not in your household, if patients 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 WORKER'S COMPENSATION 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 ____ **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	❑	❑
Discharge from Nipples	❑	❑	Previous Mammogram	❑	❑
Lumps in Breast	❑	❑	Change in Breast Size	❑	❑
Menstrual Problems	❑	❑	Did/do you breast feed	❑	❑

Age at 1st Pregnancy? ________

Year ____________

Other Problems: ______________________

____

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

REQUIRED WORKER'S COMPENSATION INFORMATION

Patient Name/ Address:

____

____

____

Patient SSN:

____

Date of Injury:

____

Name/Address/Number of Employer:

____

____

____

Job Title:

____

Job Duties:

____

How did the injury occur? ______________________________________

____

Are you currently working? __________

If yes, since when? ___________

Amount of time spent out of work due to this injury:

________Months ________Weeks ________ Days

WORKER'S COMPENSATION INSURANCE INFORMATION

Carrier Name & Address:

____

____

____

Policy #:

____

Claim #:

____