South Shore Cosmetic Surgeons, LLC

Patients Name _____
Last First Middle

Address: _____
Street & Apt # City State Zip Code

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

Referred By: _____ **E-Mail:** _____

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

Age _____ **Date of Birth:** _____ **Sex Assigned at Birth:** ❑ **Female** ❑ **Male**

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

Any restrictions for contacting you? ❑ **Yes** ❑ **No** **Contact Restrictions:** _____

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 and/or 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 and/or 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, LLC – Health Questionnaire

Name: _____ Referred By: _____

Primary Physician & Location: _____

Reason(s) for seeing Doctor today: _____

Do you smoke? ❑ Yes ❑ No If yes, how much? _____

Do you drink alcohol? ❑ 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	❑	❑	_____

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 #: _____