REGISTRATION for office of Amelia Pare MD 123 Hidden Valley Road

Date of Visit_____Name:_____

Date of Birth:_____Age:_____Male____Female____ Race:_____

Last 4 Digits Social Security#_____ Marital Status: Single Married Divorced Widow

Address:_____City:_____State:___ Zip:_____

Home phone:_____Cell:_____Work:_____

Email address:_____

Occupation: _____

Emergency Contact:_____Relationship:_____ Phone#_____

Pharmacy name/location:_____Pharmacy Phone:_____

Family physician:_____Physician Phone:_____

May we leave a message on your voicemail/answering machine at home ? Yes__ No__

May we leave medical information with a family member? Yes__ No__

May we contact you at work? Yes ___No___

Source of referral? Family physician Friend Other, explain_____

INSURANCE Information

Primary Insurance:_____

Member ID:_____Group:_____

Phone number:_____Address:_____

Policy holder name: _____Date of Birth:_____

Relation to Insured: Spouse Parent Self Copay:_____

Secondary

Insurance:_____

Member ID:_____Group :_____

Phone number:_____Address:_____

Policy holder name: _____Date of Birth:_____

Relation to Insured: Spouse Parent Self Copay:_____

Financial Authorization: I hereby authorize Dr Amelia Pare' to furnish information to insurance carriers and or health care providers concerning this illness/accident. I hereby irrevocable assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

Signature of responsible party:_____Date:_____

Photo Authorization I hereby authorize Amelia Pare to take my photograph and use it in my chart for insurance authorization.

Signature of responsible party:_____Date:_____

Authorization for Disclosure of Protected Health Information: *I authorize the entity listed below to receive my protected health information.* The protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice of Dr Pare'. This authorization will expire at the end of calendar year of your last signature below. I have the right to terminate at any time. The privacy policy is detailed and available in the reception area and upon request. I acknowledge that I am aware of the privacy practices of Dr Pare' and give my consent to Dr Pare to perform medial services necessary for the benefit of my health. Dr. Pare is the privacy officer. For telemedicine patients, please let us know if you would like copies of these policies.

*Family Doctor:*_____Date:_____

*Spouse/Partner:*_____Date:_____

Other_____relationship_____Date:_____

Signature of responsible party:_____Date:_____

Medicare Certification: I certify that the information given to me in applying for payment under Title XIX of the Social Security Act is correct. I authorize the use of my protected health information to be released to the Centers for Medicare and Medicaid. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the physician providing the services.

Signature of responsible party: _____Date:_____

Dr Pare complies with all applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, or sexual orientation. Welcome to our practice.

Name_____ **Date of Birth**_____Height_____Weight_____
Reason for visit and duration: _____**(Panniculectomy)**
Drug Allergies and reaction: _____Latex allergy: Yes No
Medications: _____
Vitamin and herbal supplements: _____
Medical conditions: _____
Hospitalizations: _____
Operations: _____

Review of Systems Have you had any of the following: If yes, *CIRCLE* please explain

Yes No Chest pain or pressure	Yes No Cancer
Yes No Heart murmur, Rheumatic fever	Yes No Wound healing problems
Yes No Blood Clots, Circulation problems	Yes No MRSA
Yes No Swelling in legs and feet	Yes No Dry Eye, Excessive tearing
Yes No High blood pressure, high cholesterol	Yes No Change in vision
Yes No Stroke	Yes No Severe headaches
Yes No Shortness of breath, asthma	Yes No Sexually transmitted Disease
Yes No Sinus Seasonal Allergies	Yes No Hepatitis
Yes No Dizziness and/or fainting	Yes No Urinary Burning, Frequency
Yes No Snoring and/or sleep apnea	Yes No Nausea, Vomiting
Yes No Hair loss, easy bruising, tiredness	Yes No Seizures
Yes No Anxiety, depression, trouble sleeping	Yes No Diabetes

Yes No *Weight loss Gastric bypass date*_____*Total weight lost*_____ *Target weight* _____

Social History
Yes No Do You smoke? How much and how long_____Would you like to quit?___
Yes No Do you consume alcohol? Amount_____

Family History If yes, please *CIRCLE* and explain what family member:
Yes No Bleeding problem _____
Yes No Diabetes _____
Yes No Heart disease/Stroke _____
Yes No Cancer, type_____
Yes No Problem with anesthesia_____

Panniculectomy Questions *Target weight?*_____*Time that weight has been stable?*_____

Circle all that apply:	Lost 100+ pounds	Had gastric bypass	Foul odor
Back Pain	Neck Pain	Use chiropractor	Weight loss program
Arthritis	Injury/MVA	Headaches	Interfere daily activity
Anxiety medication	Unable to exercise	Use Heat/Ice	Use physical therapy
Use over-the-counter pain medication daily	Use prescription pain medication daily	Unable to perform home duties	Unable to perform work duties
Wear abdominal girdle	Abdominal Skin Infections	Use cream & powder for skin irritations	

How long has your weight been stable? Months_____ Years_____ Decades_____
You will need documentation of 3 office visits from your PCP documenting rashes.
How does this skin apron interfere with your daily life? _____
If your BMI is high then additional breast tissue may need to be removed, healing may be delayed, or you may be required to lose weight. ***Patient signature***_____
This form is completed by the patient and reviewed by the physician on _____