

**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: \_\_\_\_\_ (Breast Reduction)  
 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

**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 \_\_\_\_\_

**Breast Reduction Questions** Bra size \_\_\_\_\_

<b>Circle all that apply:</b>	Back Pain	Neck Pain	Shoulder Pain
Shoulder Grooving	Hand Numbness	Arthritis	Injury/MVA
Headaches	Interfere daily activity	Unable to exercise	Use support Bras
Use over-the-counter pain medication daily	Use prescription pain medication daily	Unable to perform home duties	Unable to perform work duties
Use Heat/Ice	Use physical therapy	Use chiropractor	Breast Skin Infections
Use cream & powder for skin irritations			

Your large breasts have been a problem for how long? Months \_\_\_\_\_ Years \_\_\_\_\_ Decades \_\_\_\_\_

*You will need documentation of 3 office visits from your PCP documenting rashes.*

How do your large breasts interfere with your daily life? \_\_\_\_\_

When was your last mammogram/results \_\_\_\_\_

*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 \_\_\_\_\_