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:____

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:____

Policy:______________________________Group :_________________________________

Phone number:_________________________Address:_______________________________

Policy holder name: _____________________Date of Birth:__________________________

Relation to Insured: Spouse Parent

Secondary

Insurance:____

Policy:______________________________Group :_________________________________

Phone number:_________________________Address:_______________________________

Policy holder name: _____________________Date of Birth:__________________________

Relation to Insured: Spouse Parent

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: ______________________________________**(Implant Removal)**
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 *Current bra size*______________ *Preop bra size*______________
When were your implants placed?__________________________Revised?_____________________
Implanting Surgeon______________Address____
Left Manufacture________________Registration____________Serial number___________________
Right: Manufacture_______________Registration____________Serial number___________________
Do you have the warrantee? Yes No Extended warrantee? Yes No___________________
Do you have a history of trauma? Yes No Breast surgery? Yes No____________________
How has your implant changed? Decreased size? More firm? Painful? Lumpy?
Have you contacted the manufacturer? Yes and what did you receive_________________ No___
When was your last mammogram/results____
If your implants are removed, the final shape and size may be unpredictable.
If your BMI is higher than 35 then healing may be delayed.
Patient signature__________________________
This form is completed by the patient and reviewed by the physician on _____________________