

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: _____ (Implant Rupture)
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 _____

Implant Rupture 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 _____