PATIENT REGISTRATION FORM

Name: [First] _____ [M.I.] ____ [Last] _____ Designation: _____

Address: _____ [Apt.] _____ City: _____

State: ____ Zip: _____ E-mail: _____ Age: _____ D.O.B: _____

☐ Male | ☐ Female Marital Status: ☐Single |☐Married |☐Divorced |☐Widowed |☐Other

Social Security #: _____ Drivers License #: _____

Home Tel: _____Mobile Tel: _____ Other Tel:_____

May we contact you at HOME? □ Yes □ No CELL? □ Yes □ No EMAIL? □ Yes □ No

Pharmacy: _____ Address:_____ Phone: _____

PCP Name: _____ Address: _____ Phone: _____

May we contact them? ☐Yes |☐No

SPOUSE CONTACT *[If applicable]*

Name: [First] _____ [Last] _____ Spouse's Cell: _____

Spouse's Employer: _____ Spouse's Work Tel: _____

EMPLOYMENT INFORMATION

☐FullTime |☐PartTime |☐Student |☐Retired |☐Other Occupation:_____
Employer/School: _____ Work Tel: _____
Work/School Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY CONTACT *[not in your household]*

Name: [First] _____ [Last] _____ Relationship to Patient: _____
Home Tel: _____ Work Tel: _____ Mobile Tel: _____
Address: _____ City: _____ State: _____ Zip: _____

REFERRAL INFORMATION

Referring Physician or Patient: _____
How did you hear about Partridge Plastic Surgery? ☐ Website ☐ Social media ☐ Friend ☐ Family
☐ Physician ☐ Other: _____

INSURANCE INFORMATION

Primary Insurance Company Name: _____ Telephone: _____
Name of Insured: [First] _____ [Last] _____ D.O.B:_____
Policy#:_____ Group#:_____

Secondary Insurance Company Name: _____ Telephone: _____
Name of Insured: [First] _____ [Last] _____ D.O.B:_____
Policy#:_____ Group#:_____

MEDICAL HISTORY

Weight:_____ Height:_____

ALLERGIES

List any **ALLERGIES** you have and describe reactions (eg. Shellfish, latex, penicillin, etc.):

Name	Reaction	Name	Reaction
1.		4.	
2.		5.	
3.		6.	

MEDICATION HISTORY:

Please list all the medications you are currently taking (including birth control pills and vitamins.)

Name	Dose	Frequency

Do you use any blood thinners? (eg. Coumadin, Warfarin, Heparin, Aspirin, Lovenox, Ibuprofen)
☐YES ☐NO

Women only: **Are You Pregnant?** ☐YES ☐NO

Pregnancies: _____ # deliveries:_____

Date of last mammogram_____ ☐Normal ☐Not normal_____

MEDICAL HISTORY:

Have you ever had the following:

	Yes		Yes		Yes
Heart disease		AIDS or HIV		Blood clots/DVT/PE	
High blood pressure		Asthma/COPD		Stroke	
Irregular heart beat		Sleep apnea/snoring		Depression/anxiety	
High cholesterol		Liver disease		Psychiatric care	
Pacemaker		Thyroid disease		Seizures	
Removable dental work		Diabetes		Cold sores/herpes	
Dry Eyes		Kidney disease		Radiation	
Substance Abuse		Cancer (What Type):			

Please list any additional medical conditions you have had: _____

□ No □ Yes Have you or any family member ever reacted badly to being put to sleep for surgery?
□ No □ Yes Have you ever had a bad reaction to local anesthetic (Novocaine, etc.)?
□ No □ Yes Are you allergic to adhesive tape?
□ No □ Yes Do you bleed unusually easily (from cuts, surgery, tooth extractions)?
□ No □ Yes Are you a slow or poor healer?
□ No □ Yes Do you form large scars or keloids?
□ No □ Yes Do you have any skin disease, hives, eczema or rash?
□ No □ Yes Do you have frequent infections or boils?
□ No □ Yes Have you taken steroid medications, accutane?
If so, how long ago? _____
□ No □ Yes Do you have, or have you, had any significant emotional problems?
□ No □ Yes Have you ever had, or been advised to seek psychiatric care?
□ No □ Yes Do you use a retinol?

SURGICAL HISTORY

(Please list all and include plastic or cosmetic surgeries)

Operation	Year	Operation	Year
1.		5.	
2.		6.	
3.		7.	
4.		8.	

FAMILY HISTORY

Do you have a family history of any medical problems? *[Fill in box for those that apply]*

	Yes		Yes		Yes
Heart disease/ Heart attack		Diabetes		Depression/anxiety	
Bleeding/clotting problem		High cholesterol		Seizures	
Cancer (Malignancy)		Thyroid problem		Breast Cancer	
High blood pressure		Hepatitis		Allergies/Asthma	

REVIEW OF SYSTEMS

Do you have, or have you ever had, any of the following?

	Yes	No		Yes	No
Sinus Trouble			Chest pain		
Fainting			Tuberculosis		
Blood Disorder			Jaw/Joint Pain		
Anemia			Hepatitis		
Headaches			Hepatitis or Jaundice		
Immune Deficiencies			Frequent UTI's		
Shortness of Breath			**IMPORTANT: Please let us know if you suspect pregnancy.**		

SOCIAL HISTORY

	Yes		
Nicotine/Smoke		How many a day?	
Alcohol		How many glass a day/Week?	
Other Drugs:		Which ones?	

Do you have any special concerns?

_____

_____

By signing this agreement, I am stating all information is true and accurate, and I agree with the conditions listed above.

Patient's Signature: _____ Date:_____

NOTICE OF PRIVACY PRACTICES

Know Your HIPAA rights
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

SECTION A: Uses and Disclosures of Protected Health Information

Under applicable law, we are required to protect the privacy of your individual health information (information we refer to in this notice as "Protected Health Information"). We are also required to provide you with this notice regarding our policies and procedures regarding your Protected Health Information (referred to as "PHI") and to abide by the terms of this notice, as it may be updated from time to time.

We are permitted to make certain types of uses and disclosures of PHI under applicable law for treatment, payment, and healthcare operations purposes. For treatment purposes, such uses and disclosures will take place in providing, coordinating, or managing healthcare and its related services by one or more of your providers, such as when your pharmacist consults with your physician or a specialist regarding your medications, treatment or condition. We may use PHI in counseling you and/or your designated caregiver or for Quality Assurance, improvement activities caes management, Pharmaceutical care, Mecial review and legal services auditing functions. We may use PHI in dispensing Prescriptions and related products and services either in the Pharmacy or when delivered to your home or other designated address.

For payment purposes, such use and disclosure will take place to obtain or provide reimbursement for providing pharmaceutical care services, such as when your case is reviewed to ensure appropriate care was rendered. For reimbursement purposes, your PHI may be disclosed to one or several intermediaries employed by your plan sponsor including but not limited to insurers, pharmacy benefits managers, claims administrators and computer switching companies.

For healthcare operations purposes, such use and disclosure will take place in a number of ways, including for quality assessment and improvement, provider review and training, underwriting activities, reviews and compliance activities; planning, development, management and administration. Your information could be used, for example, to assist in the evaluation of the quality of care you were provided.

For delivery services we may authorize a commercial carrier or our delivery personnel to leave a package without your signature unless you notify us in writing not to follow this practice.

In addition, we may contact you to provide refill reminders, health screenings, wellness events, inoculations, vaccinations or information about treatment alternatives or other health-related benefits and services that may be of interest to you. In addition, we may disclose your health information to your plan sponsor. In addition, we may contact you for the purpose of fund raising activities, unless you object.

We may use and disclose your PHI, without your authorization, when the pharmacy needs to contact a physician or physician's staff and is permitted or required to do so without individual written consent or authorization. We may use and disclose your PHI if we are contacted by another pharmacy who states they have your request and consent to transfer pharmacy records to them.

From time to time, we may employ the services of business associates who may assist us in one or more tasks and who may use, change or create PHI. Business associates are required to comply with all the privacy regulations on your behalf. An example of a business associate would be our Pharmacy Software Vendor.

We may disclose PHI about you without your authorization to comply with workers compensation laws, as required by law enforcement, legal proceedings, public health requirements, health oversight activities and as required by law.

Other uses and disclosures will be made only with your written authorization, and you may revoke your authorization at any time by notifying us as described in Section B, except to the extent the Pharmacy has already taken action in reliance on a previously signed authorization form.

You may ask us to restrict uses and disclosures of your PHI to carry out treatment, payment, or healthcare operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, we are not required to agree to your request.

You have the right to request the following with respect to your PHI: (i) inspection and copying; (ii) amendment or correction; (iii) an accounting of the disclosures of this information by us; (We are not required to account to you for disclosures made for treatment, payment, operations, disclosures to you, disclosures to your care givers, for notifications or as otherwise excluded by law); and (iv) receipt of a paper copy of this notice upon request. The Pharmacy may require patients to make requests for access to their PHI in writing. The Pharmacy may charge reasonable charges for requests for PHI greater than one year in age from the date of the request. PHI must be retained by the Pharmacy for at least six years.

In addition, you may request, and we must accommodate the request, if reasonable, to receive communications of PHI by alternative means or at alternative locations. This applies mainly to requests for PHI to be sent to Post Office Boxes rather than the address on file or to a phone number other than the number on file. To make this request please contact us as described in Section B.

The Pharmacy may charge for supplies, labor and the postage involved in preparing PHI for your request. If you desire a price quote for this service you must request one. You have the right to withdraw your request of the PHI prior to the delivery.

We may use your name to reference your prescriptions and pharmaceutical care services. You may be required to sign a signature log form or to acknowledge receipt of service, to acknowledge receipt of this notice and the disclosure of PHI as outlined herein. We may disclose this information to other persons who ask for you or your prescriptions by name. You may restrict or prohibit these uses and disclosures by notifying a pharmacy representative orally or in writing of your restriction or prohibition. We are not required to honor those requests. If you request our services, we are able to provide treatment services to you, even if you object to signing the acknowledgment of the receipt of this notice or if we decide not to honor a request regarding the information in this document while noting your requests and refusals in our records. In the event of an emergency or your incapacity, we will do in our reasonable judgment what is consistent with your known preference, and what we determine to be in your best interest. We will inform you of any such uses or disclosures under such circumstances and give you an opportunity to object as soon as practicable.

We may disclose to one of your family members, to a relative, to a close personal friend, or to any other person identified by you, PHI that is directly relevant to the person's involvement with your care or payment related to your care. In addition, unless you object, we may use or disclose the PHI to notify, identify, or locate a member of your family, your personal representative, another person responsible for care, or certain disaster relief agencies of your location, general condition, or death. If you are incapacitated, there is an emergency, or you object to this use or disclosure, we will do what in our judgment is in your best interest regarding such disclosure and will disclose only the information that is directly relevant to the person's involvement with your healthcare. We will also use our judgment and experience regarding your best interest in allowing people to pick-up filled prescriptions, or similar forms of PHI, or in providing delivery of same.

We reserve the right to change the terms of this notice and to make new notice provisions effective for all PHI we maintain. You may receive a copy of this notice by contacting us as outlined in Section B or upon the receipt of pharmacy care services.

If you believe that your privacy rights have been violated, you may file a complaint with us at the location described in Section B or to the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

Section B: Contacting Us

You may contact us for further information at:
Privacy Officer
Joanna L. Partridge MD, PC.
213 N. Center Drive
North Brunswick, NJ 08902
www.partridgeplasticsurgery.com

Receipt of Notice of Privacy Practices

I have received a copy of the Joanna L. Partridge, MD, PC's Notice of Privacy Practices.

Patient Signature: _____ **Date:** _____

Release of Records

I authorize the release of my medical information to the following other people:

_____

If no one is listed, records will only be released to you or as required by law. Please consider if you wish to allow family members any access to you information when completing this section.

Patient's Payment Responsibility

I understand that I am financially responsible for all charges for all medical bills incurred while under the care of Joanna L. Partridge, MD, PC including the balance remaining after payment of possible insurance benefits. In the event that my account is not paid and forwarded to a collection agency, I shall be liable for any and all costs of collection, including but not limited to an extra 33.33% of the balance and all court costs incurred to the doctor. I further understand that there will be a $10 per month service fee if my unpaid account balance is greater than $25, and that there will be a $20 service charge for any returned checks for insufficient funds. My signature below indicates that I have read and understand the above terms and conditions.

Signed (Patient or Parent if Minor): _____ Date: _____

Assignment of Benefits

I authorize payment of medical benefits directly to Joanna L. Partridge, MD, PC on my behalf for all professional services rendered. I authorize Joanna L. Partridge, MD, PC to submit claims to Medicare and/or other medical insurance carriers on my behalf. My refusal to sign indicates that I will be responsible for all charges I incur at the time services are rendered, and must seek third-party reimbursement independently. I further authorize that photocopies shall be valid as originals.

Signed: _____ Date: _____

Release of Information

I authorize the release of any medical information necessary to process this claim or as required by law.

Signed: _____ Date: _____

AUTHORIZATION FOR AND RELEASE OF MEDICAL PHOTOGRAPHS/SLIDE/AND/OR VIDEOTAPES

INSTRUCTIONS

This consent document has been prepared to help inform you concerning permission to take photographs, slides, and/or videotapes and to use these images for a purpose as defined within this consent document.

It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by your plastic surgeon.

INTRODUCTION

Medical photographs/slides and videotapes may be taken before, during, or after a surgical procedure or treatment. Consent is required to take such images.

Additionally, patients may consent to release these medical photography/slides, and videotapes for a stated purpose.

1. CONSENT TO TAKE PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize _____Joanna L. Partridge, M.D._____and/or her associates or licenses to take pre-operative, intro-operative, and post-operative photographs, slides, and/or videotapes. I additionally consent to photographs, slides, and/or videotapes of my interview.

2. CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize _Joanna L. Partridge, M.D._ and/or her associates or licenses to use pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes for professional medical purposes deemed appropriate including but not limited to showing these images on websites on public or commercial television, electronic digital networks, for purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/or my interview.

Patient Signature: _____ **Date:** _____