KESSLER-HOSCHANDER PLASTIC SURGERY GROUP, P.C.

DATE:__________________

PATIENT NAME:______________________________ SEX (M)________(F)______

STREETADDRESS:____

CITY:____________________________________STATE:_______________ZIP CODE:_________

HOME PHONE #_____:___________________CELL PHONE # _____:______________________

DATE OF BIRTH:________________AGE:_________

PATIENT SS (Last Four Digits)______________________________

EMAIL ADDRESS:____

FAMILY DOCTOR/PEDIATRICIAN:___________________________PHONE#________________

ADDRESS:____

WHO WERE YOU REFERRED BY:____

REASON FOR VISIT:____

KESSLER-HOSCHANDER PLASTIC SURGERY GROUP, P.C.

PHARMACY NAME:____

ADDRESS:____

CITY:________________________________ZIP CODE:__________________________

PHONE#:____

IN CASE OF EMERGENCY PLEASE NOTIFY:____

RELATIONSHIP TO PATIENT:_________________________PHONE#:________________

PATIENT'S OR GUARDIAN'S EMPLOYER:____

ADDRESS:____PHONE#:________________

INSURANCE INFORMATION:

PRIMARY

CARRIER:_______________________ POLICY HOLDER'S NAME:_________________________________

DOB:___________________RELATION TO THE PATIENT: ____

SECONDARY

CARRIER:______________________ POLICY HOLDER'S NAME:_________________________________

DOB:___________________RELATION TO THE PATIENT: ____

IS YOUR VISIT THE RESULT OF AN ACCIDENT? IF YES, PLEASE COMPLETE BELOW.

DATE OF ONSET/ACCIDENT:____________________

ACCIDENT DESCRIPTION:____

HOW/WHERE DID INJURY OCCUR:____

WAS PATIENT INJURED ON THE JOB?(YES)____(NO)___/IN AN AUTO ACCIDENT?(YES)___(NO)__

FOR ON THE JOB INJURY:

DATE OF ACCIDENT:_____________TIME:___________AM/PM TOWN OF ACCIDENT:_____________

DESCRIPTION OF ACCIDENT:____

EMPLOYER:____SUPERVISOR:___________________________

INSURANCE COMPANY:__________________________ADDRESS:__________________________________

PHONE#:_________________________________CONTACT:_______________________________________

POLICY#:_______________________CARRIER CASE#:___________________WCB CASE#:_____________

ARE YOU STILL WORKING?(YES)________(NO)________ DATE LAST WORKED:___________________

FOR AUTOMOBILE ACCIDENT: (Please supply copy of insurance ID Card)

DATE OF ACCIDENT:______PATIENT WAS: DRIVER:_____PASSENGER:_____PEDESTRIAN:___WORKING AUTO___

NAME OF POLICY HOLDER:___________________________PHONE #:______________________________

INSURANCE COMPANY:_______________________________ADDRESS:____________________________

PHONE#:____CONTACT:____________________________

POLICY#:____FILE#:_________________________________

PLEASE NOTE: IF YOUR INSURANCE REQUIRES A REFERRAL, IT IS YOUR RESPONSIBILITY TO SUPPLY US WITH IT PRIOR TO SEEING THE DOCTOR. FAILURE TO DO SO WILL RESULT IN THE PATIENT BEING RESPONSIBLE FOR THE BILL.

INSURANCE PAYMENT ORDER & AUTHORIZATION TO RELEASE INFORMATION:

I HEREBY AUTHORIZE MY INSURANCE COMPANY(S) KNOWN BY THE NAME(S) OF_______________________

TO PAY DIRECTLY TO KH PLASTIC SURGERY, P.C., BENEFITS DUE ME OUT OF INDEMNITY UNDER THE TERMS OF MY POLICY. PAYMENT IS AUTHORIZED UPON YOUR RECEIPT OF THEIR ITEMIZED BILL. THE POLICY WAS IN FULL FORCE AND EFFECT AT THE TIME SERVICES WERE RENDERED IN THE EVENT THAT WILL HACVE TO REFER TO YOUR ACCOUNT FOR LEGAL ACTION, ANY AND ALL REASONABLE COLLECTION AND/OR ATTORNEY FEES WILL BE ADDED TO THE PATIENT'S BILL.

I HEREBY AUTHORIZE KH PLASTIC SURGERY, P.C. TO FURNISH INFORMATION TO THE INSURANCE CARRIER AND/OR EMPLOYERS CONCERNING ILLNESSS AND TREATENT RECEIVED BY ME FOR THE PURPOSE OF PROCESSING MY CLAIM(S) FOR MEDICAL SERVICE.

INSURED NAME:____

LEGAL SIGNATURE:____ DATE:______________

KESSLER-HOSCHANDER PLASTIC SURGERY PLASTIC SURGERY GROUP, P.C.

AUTHORIZATION FOR THE TAKING AND RELEASE OF PHOTOS

I, the undersigned patient, hereby consent to allow the doctors of **KH PLASTIC SURGERY** to take, and or release clinical photographs of me. I understand that these images may be used for any or all of the following purposes

My surgical planning

Resolution of my insurance claim(s)

Patient and/or public education

Marketing/ Promotional (including website)

If I have any exceptions to the above they are listed as follows

____

____

With the exception of any particular items indicated by me on this form, I consent to the above stated of said photographs.

Signature: ____ Date: _________________________

Witness: ____ Date:__________________________

KESSLER-HOSCHANDER PLASITIC SURGERY GROUP, P.C.

I wish to designate the following person(s) to be able to speak on my behalf and have access to my **Protected Health Information**:

1.____________________________________

2.____________________________________

3.____________________________________

4.____________________________________

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I have been provided with a copy of **KH Plastic Surgery's** privacy notice.

____

Signature

____

Print Name

____

Date

KESSLER-HOSCHANDER PLASTIC SURGERY GROUP, P.C.

MEDICAL HISTORY FORM

PATIENT NAME:____**DATE:**_____________________

HEIGHT:_________**WEIGHT:**________**WEIGHT LOSS:**________**GAIN:**_______**IN PAST YEAR:**________

NAME & ADDRESS OF YOUR DOCTOR: ____

____

PLEASE LIST ALL SURGERIES

Operation Year Hospital Doctor Local or General Anesthesia?

____

____

____

ARE YOU CURRENTLY BEING TREATED FOR ANY ILLNESS OR CONDITIONS? If so please list:

____

____

____

CURRENT MEDICATIONS (Please list all medications you are now taking and their dosages, including birth control pills, diuretics or water pills, blood pressure or heart medication, pain medications, or any other prescribed or over the counter medications) ____

____

____

DO YOU SMOKE? (YES)____(NO)____ IF SO, HOW MUCH?_______________________________________

ARE YOU ALLERGIC TO ANY MEDICATIONS? (YES)_____(NO)____ If yes, Please list:

____

____

PERTINENT PRE-OPERATIVE INFORMATION:

Have you or a family member ever reacted badly to anesthesia? **(YES)____(NO)____**If yes, Please explain:

____

SIGNATURE OF PATIENT OR OTHER:_______________________________________**DATE:**___________

(If "other" please indicate relation)**:**____