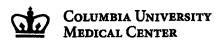


### **DEPARTMENT OF SURGERY**

**Registration Form** 

FC	R OFFIC	E USE	ONLY		at 16.2		
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12.6	N. 5. CO. S. CO.	Account to		12-13- Dis	(E)		2019

Appointment w/:					Today's Date:					
Patient Information	**									
Last Name				First Name			M			
Date of Birth Age					Sex		Marital Sta	tus		
Street Address				City/State Zip Code						
Home Phone #	( )	Mobile #	( )	Work#	( )	Email				
Mother's First Nar	me:				Father's Fir	st Name:				
Employer Informa	ation:		This is for m	nedical record pu	rposes only.			<del></del>		
Occupation			Employer's	Name/Add	ress					
Emergency Conta	ct Information:	<del></del>	<u> </u>							
Name				Relationshi			Phone # (	)	-	
Referral Source (F	rom whom/ho	w did you he	ar about tl	his Provider	?):					
Name/Type: 🗆 Pl	nysician 🗌 Fam	ily or Friend	☐ Website	e/ Search 🗆	] Advertiser	ment 🗆 Otl	her			
Primary Care Phys	ician		Address					Phone#	-	)
Cardiologist		-	Address					Phone#	(	)
Physician (Other)			Address	-			i	Phone #	(	)
Insurance Informa	ation:									
Patient Relations		r (circle one	) SELF	SP	OUSE		IDENT CHILD	) :	STUDENT	Γ
Primary Insurance						Policy #				
Guarantor Name						DOB				
Secondary Insuran	Secondary Insurance Policy #									
Guarantor Name						DOB				
Pharmacy Informa										
Circle One:	Retail Pharmac	У	Mail-Orde	r Pharmacy		Name				
Address							Phone # (	)	-	
Authorization for Tr										
I hereby authorize and direct the above named clinical practice having treated me, to release to governmental agencies, insurance carriers, or others financially liable for my medical care, all information needed to substantiate payment for such medical care; and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. I furthermore authorize the treating physician/pracitce to take and use my photos for insurance predetermination and educational purposes.										
	Financial Responsibility (For Provider Indicated in the "Appointment w/" section of this form)									
Medicare Patients: I request that payment of authorized health insurance benefits be made to me or on my behalf to the provider(s) for any services furnished to me by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration, and its agents, any information needed to determine these benefits or the benefits payable for related services.  Commercial/Other Insurance: I hereby authorize direct payment of surgical/medical benefits to my provider, for services rendered by him/her in person or under his/her supervision if I have not paid in advance. I understand that I am financially responsibly for all services. Additionally, I understand that all bills are my responsibility if not paid by the carrier.  Out of Network: I understand that the doctor is a non-participating provider of my insurance and therefore I will be responsible for any balances on this account.  Self-Pay: I agree to pay at the time the services are rendered.										
I verify the accuracy of				Patient (Guardi	ian) Signature				Date	
treatment and release				х						
I understand and agree indicated on this form.	e to terms of my fin	ancial responsi	bility as	Patient (Guardi	ian) Signature				Date	



Jeffrey Ascherman, MD

161 Fort Washington Avenue, N Y, 10032 Office 212-305-9612 Fax 212-305-9626

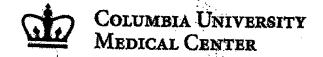
Patient Name:

MRN

Please answer the questions below:	
Please list ALL of your current medications:	
	,
ist any allergies and reactions (including rash, hives, throat swelling, anaphyla	xis)
	-
ist any supposite you have had and the anyyevimate date:	
<u>ist any surgeries you have had and the approximate date:</u>	

Bajent Names

HAVE YOU EVER HAI describe):	(been diagnosed or trea	ated for) ANY OF THE FOL	LOWING (if yes,
Heart Disorder	YesNo		
Cancer	YesNo		
Diabetes	YesNo		
Blood Pressure Disorder	YesNo		
Thyroid Disorder	YesNo		
Lung Disorder	YesNo		
Stomach/Intestinal Disord	ler YesNo		
Skin Disorder	YesNo		
Clotting Disorder	YesNo		
Psychologic Disorder	YesNo		
Urinary/Kidney Disorder	YesNo		
Liver Disorder	YesNo		
Orthopedic Disorder	YesNo	_	
Cholesterol Disorder	YesNo		<u> </u>
Neurologic Disorder	YesNo		
Other	YesNo		
SOCIAL HISTORY:			
Occupation:			
Children? YesNo	ages	_	
<u>Smoking</u> :			
Currently? YesNo	-		
Previously? YesNo	_ Years Smoked	_ packs per day	
PHYSICAL EXAM:			
Heightft	_in Weight	lbs.	



Health Insurance Portability and Accountability Act (HIPAA) HIPAA Compliance/Columbia University Medical Center 601 West 168th Street, Apr. #22, 2nd Floor New York, NY 10032/ T(212) 342-0059 F(212)342-5173 http://www.cumc.columbia.edu/hipaa/

# NOTICE OF PRIVACY PRACTICES

### ACKNOWLEDGEMENT OF RECEIPT

DATE:	
•	
I acknowledge that I was provided with Medical Center Notice of Privacy Pract	
Patient Name (Print)	Patient Signature
	en de la companya de La companya de la co
If completed by a patient's person	al representative, please print and
sign your name i	n the space below
Personal Representative (Print)	Personal Representative's Signature
	Relationship
	154.72
For Columbia University Medical Center	use only.
Complete this section if this form is not sign representative.	ed and dated by the patient or patient's
	a written acknowledgement of receipt of tice of Privacy Practices but was unable to
for the following reason:  Patient refused to sign	
<ul> <li>Patient unable to sign</li> </ul>	<b>.</b>
□ Other	
Employee Name	Date

This form should be placed in the patient's medical record

1.

Revised October 2007

# New York Presbyterian Division of Plastic Surgery 161 Fort Washington Avenue, New York, NY 10032 Office 212-305-9612 Fax 212-305-9626

## **Medication List (Please Print Legibly)**

Medication	Dosage	# Times a day	Reason for Medication (e.g. High Blood Pressure)

Please fill out medications, dosages prescribed with, and how many times a day. Also include herbs, Vitamins, Minerals, and any other Supplements that you are currently taking.

Patient name (print)	Date	
- ·		
Signature		