COLUMBIA UNIVERSITY MEDICAL CENTER

DEPARTMENT OF SURGERY

Registration Form

FOR OFFICE USE ONLY	
MRN:	Div:

Appointment w/:	Today's Date:

Patient Information:

Last Name		First Name		M
Date of Birth	Age	Sex	Marital Status	
Street Address		City/State		Zip Code
Home Phone # ( ) -	Mobile # ( ) -	Work# ( ) -	Email	
Mother's First Name:		Father's First Name:		

This is for medical record purposes only.

Employer Information:

Occupation	Employer's Name/Address

Emergency Contact Information:

Name	Relationship	Phone # ( ) -

Referral Source (From whom/how did you hear about this Provider?):

Name/Type: ☐ Physician ☐ Family or Friend ☐ Website/ Search ☐ Advertisement ☐ Other _____

Primary Care Physician	Address	Phone# ( ) -
Cardiologist	Address	Phone# ( ) -
Physician (Other) _____	Address	Phone # ( ) -

Insurance Information:

Patient Relationship to Guarantor (circle one) **SELF** **SPOUSE** **DEPENDENT CHILD** **STUDENT**	
Primary Insurance	Policy #
Guarantor Name	DOB
Secondary Insurance	Policy #
Guarantor Name	DOB

Pharmacy Information:

Circle One: **Retail Pharmacy** **Mail-Order Pharmacy**	Name
Address	Phone # ( ) -

Authorization for Treatment and Release of Information

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 the above information and authorize treatment and release of information as indicated on this form.	**Patient (Guardian) Signature** X	**Date**
I understand and agree to terms of my financial responsibility as indicated on this form.	**Patient (Guardian) Signature** X	**Date**

COLUMBIA UNIVERSITY
MEDICAL CENTER

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:

_____

_____

_____

List any allergies and reactions (including rash, hives, throat swelling, anaphylaxis)

_____

_____

_____

List any surgeries you have had and the approximate date:

_____

_____

Patient Name: _____

HAVE YOU EVER HAD (been diagnosed or treated for) ANY OF THE FOLLOWING (if yes, describe):

Heart Disorder	Yes__No__	_____
Cancer	Yes__No__	_____
Diabetes	Yes__No__	_____
Blood Pressure Disorder	Yes__No__	_____
Thyroid Disorder	Yes__No__	_____
Lung Disorder	Yes__No__	_____
Stomach/Intestinal Disorder	Yes__No__	_____
Skin Disorder	Yes__No__	_____
Clotting Disorder	Yes__No__	_____
Psychologic Disorder	Yes__No__	_____
Urinary/Kidney Disorder	Yes__No__	_____
Liver Disorder	Yes__No__	_____
Orthopedic Disorder	Yes__No__	_____
Cholesterol Disorder	Yes__No__	_____
Neurologic Disorder	Yes__No__	_____
Other	Yes__No__	_____

SOCIAL HISTORY:

Occupation: _____

Children? Yes__No__ ages _____

Smoking:

Currently? Yes__No__

Previously? Yes__No__ Years Smoked_____ packs per day_____

PHYSICAL EXAM:

Height _____ft _____in Weight _____lbs.

COLUMBIA UNIVERSITY
MEDICAL CENTER

Health Insurance Portability and Accountability Act (HIPAA)
HIPAA Compliance/Columbia University Medical Center
601 West 168th Street, Apt. #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 a copy of the Columbia University Medical Center Notice of Privacy Practices.

_____ _____
Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below

_____ _____
Personal Representative (Print) Personal Representative's Signature

_____
Relationship

For Columbia University Medical Center use only.

Complete this section if this form is not signed and dated by the patient or patient's representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Columbia University Medical Center's Notice of Privacy Practices but was unable to for the following reason:

- ☐ Patient refused to sign
- ☐ Patient unable to sign
- ☐ Other _____

_____ _____
Employee Name Date

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

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 _____