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**

Division of Plastic and Reconstructive Surgery
New York-Presbyterian Hospital
PATIENT HISTORY QUESTIONNAIRE

Are you currently under the care of or have you ever been treated by a Medical Physician for any significant reason other than flu or virus

____

____

____

____

Have you had any Surgical Procedures in the past?

Date	Type of Surgery	Name of Doctor/Hospital

Do you have any bleeding tendencies? Yes _______ No ______
Do you have any allergies to medications? Yes _______ No ______

PENICILLIN YES _____ NO _____
LOCAL ANESTHETIC YES _____ NO _____
ANY OTHERS YES _____ NO _____

IF YES PLEASE SPECIFY:____

____

____

Are you presently taking any medications? ___________
ASPIRIN YES_____ NO______
ORAL CONTRACEPTIVES YES_____ NO______ HEIGHT___________
BLOOD THINNERS YES_____ NO______
ANY OTHERS YES_____ NO______ WEIGHT __________

IF YES PLEASE SPECIFY:
MEDICATION:____
DOSAGE:____
FREQUENCY:____

DO YOU DRINK ALCOHOL YES ____ NO_____ IF SO HOW MUCH?__________
DO YOU SMOKE CIGARETTES YES ____ NO_____
IF YES HOW MANY PACKS A DAY _______

IF YOU HAVE ANY HISTORY OF USE OF CONTROLLED SUBSTANCES PLEASE BRING IT TO YOUR DOCTOR'S ATTENTION

REVIEWED BY __________

ROBERT T. GRANT MD, MCs, FACS

CERTIFIED AMERICAN BOARD OF PLASTIC SURGERY
SURGEON-IN-CHIEF
NEW YORK-PRESBYTERIAN HOSPITAL/COLUMBIA UNIVERSITY MEDICAL CENTER AND
NEW YORK-PRESBYTERIAN HOSPITAL/WEILL CORNELL MEDICAL CENTER

Patient Name: Date :	**What is your reason for your visit today?**

Other than the services we have already provided for you, what additional services would you like to learn about? Please check all that apply

❑ Breast size	❑ Nose size or shape	❑ Injectable Treatments (Botox)
❑ Abdominal area	❑ Drooping brow	❑ Juvederm/Restylane/Radiesse
❑ Hips	❑ Drooping eyelids	❑ Facial fine lines/wrinkles
❑ Legs	❑ Mole removal	❑ Thin lips
❑ Facial Contouring	❑ Scar revision	❑ Length/Fullness of Eyelashes
❑ Body Contouring	❑ Neck wrinkles	❑ Facial fullness/drooping
❑		

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		*True Age*		*Older Than*
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

How did you hear about us?

❑ My physician	*Full name:*
❑ A friend or family member	*Name:*
❑ Dr Grant's web site	*Specify Ad:*
❑ The hospital web site	*Name:*
❑ Web search	
❑ Newspaper or magazine article	
❑ Seminar	*Date/location:*
❑ Other	

❑ Approval to contact you.	*Best phone number to reach you:*
❑ Approval to add you to our e-newsletter list (including special offers)	*Email address:*

❑ *I'm not interested in any additional services provided at this time*

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

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 ____