



Patient Registration

Last Name:		First Name:		MI
Address, City, State ZIP				
Phone #		Cell Phone #		E-Mail
Date of Birth		Social Security #		Sex: M or F
Employer Information				
Employer Name		Work Number #		Occupation
Employer Address, City, State ZIP				
Marital Status S D W Sep M			Spouse Name & Date of Birth	
In case of emergency contact name			Contact phone #	
May we discuss your medical care: <input type="checkbox"/> No <input type="checkbox"/> Yes - Any restrictions to what we may disclose?				
Pharmacy Name			Pharmacy Phone #	
Insurance Information				
Primary Care Physician			Physician Phone #	
Insurance Name			ID #	Group #
Subscriber Name:			Date of Birth	Social Security #
Subscribers Employer			Subscribers Employer Phone #	
Responsible Party (for minors only)				

Assignment & Release

I authorize the release of any information including diagnosis and records of any treatment in order to carry out treatment, payment and health care operation. A notice of my privacy rights has been offered to me. I authorize and request my insurance company to pay directly to RiverSong Plastic Surgery. I understand that my insurance carrier may pay less or none of the services I am receiving. I agree to be responsible for payment in full of services rendered on my behalf or my dependents. I also understand that if my insurance requires referrals I am responsible for getting these prior to my visits, otherwise full payment will be paid at the time of visit.

Signature: _____ Date: _____



Name:	Date of Birth/Age:	Today's Date:
Reason for this visit today?		

Are you allergic to any of the following?

- Latex
 Novocaine
 Iodine
 Penicillin
 Codeine
 Aspirin
 Adhesive Tape

If yes to any of the above, what reaction do you have?

Do you have any other allergies/sensitivities? No Yes - explain: _____

Medical Information: Have you ever had, or been treated for any of the following?

Cardiac

- High Blood Pressure
- High Cholesterol
- Chest Pain/Angina
- Heart Attack
- Heart Failure
- Stents/Cardiac Surgery
- Taking Coumadin
- Taking Plavix
- Bleeding or Bruising
- Irregular Heart Beat
- Pacemaker
- Implanted Defibrillator

Vascular

- Stroke
- Poor circulation legs
- Varicose Veins
- Swollen Legs
- Blood Clots in Legs
- Blood Clots in Lungs
- Leg Ulcers

Eye, Ear, Nose, Throat

- Glaucoma
- Visual Problems
- Dry Eyes
- Sinus Problems
- Environmental Allergies
- Hearing Problems

Respiratory

- Asthma
- Emphysema/COPD

- Sleep Apnea/CPap

- Anesthesia Problems

- Short of Breath

Endocrine

- Diabetes:

- Diet Controlled

- Oral Med Controlled

- Insulin Controlled

- Diabetic Eye Problems

- Diabetic Kidney Problems

- Numbness in Feet and Legs

- Thyroid Disease

Gastrointestinal

- Acid Reflux (GERD)

- Ulcers

- Stomach Problems

- Black/Bloody Stool

- Crohn's/Ulcerative Colitis

- Gall Stones

- Gastric Bypass

- Hepatitis/Liver Disease

Genitourinary

- Kidney Stones

- Chronic Bladder Infections

- Hysterectomy

- Prostate Problems

Breast

- Breast Cancer

- Breast Infections

- Nipple Discharge

- Breast Pain

- Breast Implants

Skin

- Skin Cancer

- Melanoma

- Previous Mohs Surgery

- History MRSA

- Rosacea

- Healing Problems

- Previous Burn

- Psoriasis

Blood/Lymph/Immune

- Chronic Anemia

- Bleeding/Bruising Problems

- HIV/AIDS

- Lupus

- Rheumatoid Arthritis

- Scleroderma

- Lyme Disease

- On Prednisone

Musculoskeletal

- Osteoarthritis

- Back Pain

- Back Surgery

- Muscle Disease

- Fibromyalgia

Neurological

- Headaches/Migraines

- Seizures

- Depression/Anxiety

- Psychiatric Care

- MS/Motor Neuron Disease

Any other Medical Problems:

Any Cancer, please list:



Name:	Date of Birth/Age:	Today's Date:
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Previous Surgery:

Please list any previous surgeries you may have had:

Medications:

Please list any prescription, non-prescription and herbal medications you are taking.

If you have a list, please provide it for us to copy.

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

Family History

Mark if any family member has the following and how they are related:

<p style="text-align: center;"><i>Relation</i></p> <p><input type="checkbox"/> Skin Cancer _____</p> <p><input type="checkbox"/> Melanoma _____</p> <p><input type="checkbox"/> Breast Cancer _____</p> <p><input type="checkbox"/> Other Cancer _____</p> <p><input type="checkbox"/> Diabetes _____</p> <p><input type="checkbox"/> Stroke/TIA _____</p>	<p style="text-align: center;"><i>Relation</i></p> <p><input type="checkbox"/> High Blood Pressure _____</p> <p><input type="checkbox"/> Heart Attack, Stents or Cardiac Surgery _____</p> <p><input type="checkbox"/> Artery Disease of the legs _____</p> <p><input type="checkbox"/> Varicose Veins _____</p> <p><input type="checkbox"/> Blood clotting or Bleeding Problems _____</p> <p><input type="checkbox"/> Anesthesia Problems _____</p>
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Social History

Single Married Divorced Widow/Widower Children, how many _____

Occupation or Primary Activity: _____

Do you Smoke No Yes, how many packs per day? _____

If you smoked in the past, when did you quit? _____

On average, how many alcoholic drinks do you have per week? _____

Have you had problems with substance abuse? No Yes, please describe _____

Height: _____ Weight: _____



Name:	Date of Birth/Age:	Today's Date:
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Authorization To Take Photographs/Record Release

PLEASE CHECK ONE:

Yes No

I do hereby authorize Michele T. Sasmor, MD to take photographs of me and use them as an aid in my treatment. Photographs may be taken in the office, wound center, operating room, or inpatient.

PLEASE CHECK ONE:

Yes No

I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for the use in examination, testing, credentialing and/or certifying purposes by the American Board of Plastic Surgery, Inc.

Patient Name (please Print)

Patient Date of Birth

Patient Signature

Date/Time

SIGNING THIS SECTION IS OPTIONAL

The undersigned hereby authorizes Michele T. Sasmor, MD to use my photographs for patient education understanding steps will be taken to prevent my identity from being disclosed.

Patient Signature

Date

Witness Signature

Date



Name:	Date of Birth/Age:	Today's Date:
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Notice of Privacy Practices-Patient Acknowledgement

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization. A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
 - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
 - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
 - The right to receive confidential communications of protected health information.
 - The right to inspect and copy protected health information.
 - The right to amend protected health information.
 - The right to receive an accounting of disclosures of protected health information.
 - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature-Patient or person authorized to consent for patient

Date

If any party other than the patient gives such consent, his/her capacity should be specified, i.e. parent, guardian, etc.

Relationship: _____



Name:	Date of Birth/Age:	Today's Date:
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Welcome to RiverSong Plastic Surgery & Timeless Faces Advanced Skin Care Clinic

Which Doctor or Esthetician are you seeing? Circle One: **Dr. Sasmor** **Anne Connolly**

- Referred by another physician, By whom? _____
- Referred by a friend or family member, By whom? _____
- Referred by a Newspaper Advertisement, Which one? _____
- Post Card
- Coupons
- Referred by internet
- Referred by the Yellow Pages
- Seminar @ _____
- Referred by other source, please elaborate _____

- Cosmetic Patient
- Skincare/Estheticians

Thank you for completing this short survey. We hope that your time with us is informative and that it fulfills your expectations.