21 Highland Avenue, Suite 3-4A
Newburyport, MA 01950
978-462-8300

Patient Registration

Last Name:	**First Name:**	**MI**
Address, City, State, ZIP		
Phone #	**Cell Phone #**	**E-Mail**
Date of Birth	**Driver's License # _____** **OR** **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: ❑ No ❑ 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 privacy rights updated on 7/23/13 is available 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. RiverSong Plastic Surgery may contact me using the above contact information.

Signature: _____ Date: _____

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Medical History

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:

_____
_____
_____

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Medical History

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

Previous Surgery:
Please list any previous surgeries you may have had:

_____

_____

_____

_____

_____

Medications:
Please list any prescription, non-prescription and herbal mediations 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:

	Relation		*Relation*
❒ Skin Cancer	_____	❒ High Blood Pressure	_____
❒ Melanoma	_____	❒ Heart Attack, Stents or Cardiac Surgery	_____
❒ Breast Cancer	_____	❒ Artery Disease of the legs	_____
❒ Other Cancer	_____	❒ Varicose Veins	_____
❒ Diabetes	_____	❒ Blood clotting or Bleeding Problems	_____
❒ Stroke/TIA	_____	❒ Anesthesia Problems	_____

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:

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*

RiverSong Plastic Surgery & Timeless Faces Survey

What is the reason for your visit today?

Lesions/spots ___ Facial filler/Botox ___

Skin Care __ True Sculpt __ Ulthera __ Surgical __ Cosmetic Surgical__

Who are you seeing today?

Dr. Sasmor __ Lara Melchionda __ Anne Connolly __ Linda Wood __ Lisa Page __

How did you hear of us?

❒ A physician, by whom? _____

❒ A friend or family member, by whom? _____

❒ RiverSong's Web Site

❒ Internet Search

❒ Facebook

❒ Email Blast

❒ Post Card

❒ Magazine

❒ Radio

❒ Seminar, where? _____

❒ Referred by other source, please elaborate _____

_____

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

9/2020