

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: <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 privacy rights updated on 5/19/2021 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: _____



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> |
|--|--|

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 and Catherine Kilmartin, 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 and Catherine Kilmartin, 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 ___ Dr. Kilmartin ___ Lara Melchionda ___ Erika Moran ___ Linda DeMoura

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.