PLASTIC SURGERY ASSOCIATES OF NORTHERN VIRGINIA, LTD.

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PLEASE PRINT **Patient Registration Form** **Today's Date:_____**

Name:_____ (H):_____

Address: _____ (C):_____

City_____ State _____ Zip Code _____ _____

Employer: _____ (W):_____

Date of Birth: ____/____/_____ Age: _____ Sex: M F Marital Status: S M D W Sep

Height:_____Weight:_____ Who referred you to our office?_____

Where should statements of your account be sent if different from above?

_____
Name Address City State Zip

In case of Emergency, who should be notified?_____ Phone _____

Primary Care Physician_____ Phone _____

INSURANCE INFORMATION (Not needed for Cosmetic Patients)

Do you require a REFERRAL for this visit?_____

Primary Insurance Name _____ ***Secondary*** Insurance Name_____

Ins. Address _____ Ins. Address_____

Name of Insured _____ Name of Insured_____

Insured's ID#_____ Insured's ID# _____

Insured's Date of Birth:_____ Insured's Date of Birth:_____

Group #_____ Group#_____

Relationship of patient to the Insured_____ Relationship of patient to the Insured_____

Do we have your permission to:

Leave a message on your answering machine at home?	YES NO
Leave a message at your place of employment?	YES NO
Discuss your medical condition with any member of your household?	YES NO

If yes, whom: _____ Relationship _____

_____ _____

Signature of patient or legal guardian **Date**

Please present insurance cards and photo ID to the receptionist so copies may be made.

-OVER-

What brings you to our office? Please be as specific as possible_____
How long have you had this condition?_____
Have you had any previous treatment for this condition?_____
If YES, how and when was this treated?_____

Review of systems:

Do you have or have you had any of the following? (Please check yes or no.)

	Yes	No		Yes	No
AIDS or HIV positive	☐	☐	Hepatitis	☐	☐
Anemia	☐	☐	High blood pressure	☐	☐
Arthritis	☐	☐	Irregular heart beat	☐	☐
Asthma	☐	☐	Kidney problems	☐	☐
Back problems	☐	☐	Migraine headaches	☐	☐
Blood clots in legs	☐	☐	Nervous breakdown	☐	☐
Blood disorders	☐	☐	Nose/throat problems	☐	☐
Bleeding problems	☐	☐	Pneumonia	☐	☐
Breathing problems	☐	☐	Psychiatric condition	☐	☐
Cancer	☐	☐	Rheumatic fever	☐	☐
Chest pains	☐	☐	Seizures	☐	☐
Colitis	☐	☐	Shortness of breath	☐	☐
Diabetes	☐	☐	Skin cancer	☐	☐
Ear/Eye problems	☐	☐	Stomach problems	☐	☐
Epilepsy	☐	☐	Stroke	☐	☐
Heart problems	☐	☐	Thyroid problems	☐	☐
Heart murmur	☐	☐	Tuberculosis	☐	☐
Heart palpitations	☐	☐	Transfusion	☐	☐

Past, Family and/or Social History:

Current medical conditions:_____

List any hospitalizations and/or previous surgery (including cosmetic/plastic surgery), with dates:_____

_____

_____

Are you allergic to or have you ever had a reaction to any medication or drug; local anesthetic; or general anesthetic?_____

Are you now or have you ever taken any medications regularly (aspirin, birth control pills, vitamins, etc.)?

Currently taking:_____

Previously taken:_____

Do you currently smoke: Yes No If yes, how many packs per day?_____How many years?_____
Have you ever smoked? Yes No If yes, how many packs per day?_____How many years?_____

Do you drink alcohol? Yes No If yes, how much?_____How often?_____

Do you have any relatives who have had breast cancer? Yes No If yes, who?_____

Have you ever had a mammogram? Yes No If yes, when was your last one?_____

Have you had exposure to any of the following?
Radiation Yes No Excessive sun Yes No

Do you have a problem with excessive scarring or keloid formation after being cut? Yes No

Is your general health good? Yes No

Have you ever had psychiatric problems, or been under the care of a psychiatrist, psychologist or mental health counselor? Yes No

Marketing Authorization

According to federal law we must ask for your permission to send to you via email or regular mail information regarding our practice such as products we sell, promotions we have or any services the practice offers (i.e., office promotions that include Botox events and/or special discounts). Our office **DOES NOT** sell our patients names.

This authorization is effective until revoked in writing.

I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form. I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying PSANV in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by PSANV in reliance on this authorization before PSANV receives my request for revocation or modification. I must sign my written request and send it to:

Privacy Contact
Plastic Surgery Associates of Northern Virginia, Ltd.
8180 Greensboro Drive #1015
McLean, VA 22102

I DO_____ **I DO NOT**_____

Authorize Plastic Surgery Associates of Northern Virginia, Ltd. ("PSANV") to use and disclose my Protected Health Information ("PHI") to mail to me any information regarding the products, services, or promotions the practice offers.

_____ _____
Patient Signature Date

_____
Email Address (Please Print)

If not signed by the patient, please indicate relationship:_____

Notice Of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. A copy of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information is available upon request. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

Patient Name:_____Relationship to Patient:_____

Signature:_____Date:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

12/6/07