JOSEPH J. HIRSCHFELD, MD. PA.

Fletcher Avenue Suite 260, Tampa, FL 33613
Phone: (813) 972-2299 Fax: (813) 972-8700
Email. info@hirschfeldmd.com Website: www.hirschfeldmd.com

PATIENT REGISTRATION FORM

DATE: _____ REFERRED BY: _____

NAME (of patient): _____ BIRTHDATE: _____ AGE: _____

ADDRESS: _____

SS#: _____ MARITAL STATUS: _____ HOME PHONE: _____

CELL PHONE: _____ WORK PHONE: _____

EMPLOYMENT/OCCUPATION: _____

EMAIL ADDRESS: _____ FINANCIALLY RESPONSIBLE PARTY: _____

NEAREST RELATIVE NOT LIVING WITH YOU: _____

PATIENT QUESTIONNAIRE

I. Please list the family members, if any, whom we may inform about your general medical condition and your diagnosis, (provide phone number for them also):

_____

II. Please list the family members, or significant other, if any, whom we may inform about your medical condition, (only in an emergency): _____

III. Please print the address of where you would like your billing statements or correspondence from our office to be sent if other than your home address.

_____

IV. Please indicate if you want all correspondence sent in a sealed envelope marked "CONFIDENTIAL":

YES_____ or NO _____

V. Please print the phone number where you want to receive calls about your appointments, labs, or other health care information if other than your home phone number: _____

VI. Can confidential messages be left on your telephone answering machine or voice mail?

YES_____ or NO _____

_____ _____

PATIENT SIGNATURE (IF UNDER 18 USE PARENT OR GUARDIAN SIGNATURE): DATE:

RELEASE AND ASSIGNMENT

I hereby authorize Joseph J. Hirschfeld, MD., PA. to release to my insurance company or physician upon request any information (ie. diagnosis, medical records, etc) for the purpose of medical treatment, medical quality assurance and peer review during the period that I am a patient of Joseph J. Hirschfeld, MD., PA. I further authorize and request that any insurance benefits due me for services rendered be paid directly to Joseph J. Hirschfeld, MD., PA. of the amount due me in my pending claim for medical expenses payable under terms of my insurance. I hereby acknowledge that I am financially responsible for any and all charges for professional services which are not paid for by my insurance, and that if the insurance has not been paid within 60 days, I am responsible for the full amount immediately. I realize that I am fully responsible for my bill, if insurance is not available to me. If collection is necessary, I am responsible for any attorney or collection fees. In connection with the use of this RELEASE and ASSIGNMENT, a photostatic copy shall be considered as valid as the original.

PERMISSION FOR PHOTOGRAPHS

I hereby give authorization to Dr. Joseph J. Hirschfeld, MD., PA. or their staff to take medical photographs preoperatively and/or postoperatively to be part of this medical record.

_____ _____

PATIENT SIGNATURE (IF UNDER 18 USE PARENT OR GUARDIAN SIGNATURE) DATE:

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MEDICAL HISTORY

GENERAL HEALTH: _____ ALLERGIES: _____

MEDICATIONS RECENTLY TAKEN

_____

_____

TOBACCO___ ALCOHOL ___ DIET PILLS ___ RECREATIONAL DRUGS ___

PLEASE CHECK ONLY THOSE CONDITIONS BELOW THAT YOU HAVE HAD:

	Adrenal Disease		Diabetes		High Blood Pressure		Scarlet Fever
	Anemia		Difficulty Swallowing		Irregular Heart Beat		Depression
	Arthritis		Dizziness		Joint Replacement		Severe Headaches
	Asthma		Emphysema		Kidney Disease		Sleep Apnea
	Bladder Infections		Epilepsy		Liver Disease		Shortness of Breath
	Bleeding Tendencies		Fracture		Mitral Valve Prolapse		Sinusitis
	Blood Disease		Gall Bladder Problems		Nasal Obstruction		Skin Hives/Eruptions
	Blood in Stools or Vomit		Glaucoma		Ovarian Tumor or Cyst		Stomach Ulcers
	HIV/AIDS		Goiter or Thyroid Dis.		Persistent Hoarseness		Stroke
	Cancer		Hearing Loss		Pituitary Disease		Swollen Lymph Nodes
	Chemo/Radiation		Heart Attack		Pregnancy		Tumors
	Chest Pain/Angina		Heart Valve Replac.		Prostate Problems		Visual Disturbance
	Cysts		Hepatitis or Jaundice		Rheumatic Fever		Weight Change

Weight: _____ Height: _____ Disabled? Yes or No

Have you ever had a spine injury? _____

Date of Injury, if any: _____

Past Surgical History _____

_____

_____

Other Remarks About Your Health: _____

_____

Reason for this consultation: _____

_____

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BAY AREA COSMETIC SURGERY CENTER
MEDICATION LIST
INCLUDING ALL OVER THE COUNTER & HERBAL MEDICATIONS

Patient Name: _____DOB:_____
ALLERGIES: _____

MEDICATION	DOSE	FREQUENCY	PRESCRIBING PHYSICIAN

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of the Office's Notice of Privacy
(Print Patient's Name)

Practices.

_____
(Print Name)

_____
(Signature of Patient or Responsible Party)

_____
(Date)

***For Office Use Only**

- **Individual refused to sign**
- **Communication barriers prohibited obtaining the acknowledgement**
- **An emergency situation prevented us from obtaining acknowledgement**
- **Other (Specify): _____**

_____

_____

_____

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Consent for Treatment

1) I authorize Dr. Joseph J. Hirschfeld, MD., PA. and whomever he designates to represent him to transmit my medical data over the telephone lines by means of fax machine, email, etc. I understand that it is possible that such transmission could inadvertently, without fault, wind up in the wrong hands, however, the timely transmission of this information is important enough for me to accept this use.
2) Healthcare workers are at risk for the transmission of Hepatitis and HIV (AIDS) by needle stick or blood. If during the course of your surgical procedure an incident occurs which could result in a risk to a healthcare worker, I agree to submit to a blood test for Hepatitis and HIV (AIDS). We certainly understand your need for confidentiality regarding such a sensitive issue.
3) I understand my insurance carrier may deem my surgery "unnecessary" and for cosmetic purposes only. If Dr. Hirschfeld feels my carrier will deny payment for the reason that the procedure(s) is purely cosmetic, or my insurance company denies payment of claim for the reason that the procedure(s) is purely cosmetic, I agree not to file a claim with my insurance carrier and I agree that I am fully responsible for payment and charges incurred.
4) I give Dr. Hirschfeld and his staff permission to transfer me to a local hospital if they deem necessary, before, during, or after surgery. I understand my insurance may not cover this expense and that I am personally and fully responsible for payment of all incurred charges.

_____

(Print Name)

_____

(Signature of Patient or Responsible Party)

_____

(Date)