

# JOSEPH J. HIRSCHFELD, MD. PA.



3212 Cove Bend Drive, Tampa, FL 33613  
Phone: (813) 972-2299 Fax: (813) 972-8700  
Email. [info@hirschfeldmd.com](mailto:info@hirschfeldmd.com) Website: [www.hirschfeldmd.com](http://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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**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.

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**(Print Name)**

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**(Signature of Patient or Responsible Party)**

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**Date**

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**Witness**