PINCUS PLASTIC SURGERY

Dr. David J. Pincus, MD, FACS

Board Certified Plastic Surgeon

PATIENT INFORMATION FORM

Legal Name - Last name: _____First name:_____

Preferred/chosen name: _____

Date of Birth : _____Age: _____

Gender identity:	What pronoun do you prefer:	What sex were you assigned at birth:
Male	She/Her/Hers	Male
Female	He/Him/His	Female
Transgender Male	They/Them/Theirs	Other
Transgender Female	Others	Decline to answer
Gender Queer		
Additional category		
Decline to answer		

Address : _____ City :_____ State: _____ Zip: _____

Home Ph : (_____) _____ Cell Ph : (_____) _____Phone Carrier : _____

SS # :_____ -_____ -_____ e-mail address : _____

Marital status : (check one) [ ] Single [ ] Married [ ] Other _____

Occupation : _____ Work ph # : (_____) _____

Employer : _____ Employer Address : _____

Primary Care Physician : _____

Address: _____ Phone # : _____

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PATIENT INFORMATION FORM (continued)

How did you hear about us?

TV/RADIO:

RADIO: BLI KJOY SHARK WALK Z100

TV: BRAVO DISCOVERY E! NEWS12 TLC CNBC VH1

HAMPTONS BILLBOARDS

REFERRAL:

Patient Referral_____

Clinical Referral_____

INTERNET SEARCH:

GOOGLE HULU YOUTUBE

REAL SELF

OTHER WEBSITE_____

OTHER:

MAGAZINE: VOGUE HAMPTONS OTHER_____

OTHER: _____

What procedures would you like to discuss today?

Surgery: _____

_____

_____

Other:_____

Non-surgical Services:

PRP

MORPHEUS 8 LASER

EMSCULPT EVOKE

SKINCARE

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Insurance Provider/Company: _____ Phone #: (_____) _____

Plan ID #: _____ Member #: _____

Policy Holder Name : _____Policy Holder Date of Birth: _____

Relationship to Policy Holder: _____

I, _____ have insurance coverage and assign directly all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I will promptly forward to the doctor all insurance payments sent to me by my insurance company for services performed by the practice.

Signature of Insured/Guardian: _____ **Date:** _____

Patient Name (Print): _____

** We will NEVER contact you by email to request personal medical information. If you receive such a request, please contact our office.*

It is important for you to know, that we do not just stop at excellent medical care. We care deeply about our patient's- so we go one step further.

As you know, dealing with insurance companies- can be time-consuming and confusing. As such, it is important to make sure your claim is processed by your insurance correctly properly- as you surely pay enough in premiums that they should shoulder the burden- leaving you with the most minimal possible co-pay/deductible responsibility.

To that end, our office employs "certified patient advocates"- in order to interface with the insurance companies on your behalf- and to make sure everything is processed smoothly and correctly.

As such, you may receive a call from a patient advocate from the firm EDRTB. If they do contact you- it is generally just to get certain insurance documents signed- in order that they can advocate and manage the claim on your behalf.

Please note- this is, of course, provided at absolutely no cost (or any obligation) to you- as it important that every patient we see- is happy and satisfied in every respect.

PHARMACY INFORMATION :

Pharmacy Name : _____ Ph # : (_____) _____

Address : _____

50 Route 111, Suite 300, Smithtown, NY 11787 P (631) 352-3556 F (631) 352-3557 C (516) 672-8279

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PATIENT INFORMATION FORM (continued)

1. Are you allergic to any medications? [ ] No [ ] Yes

Medication : _____ Reaction : _____

Medication : _____ Reaction : _____

Medication : _____ Reaction : _____

2. Are you allergic to latex ? : [ ] No [ ] Yes Reaction : _____

3. Other allergies including any food allergies ? : [ ] No [ ] Yes
_____ Reaction:

Are you pregnant or breast feeding ? : [ ] No [ ] Yes

# of pregnancies ? : _____ # of vaginal births ? : _____ # C – Sections ? : _____

Height : _____ ft _____ inches Weight : _____ lbs.

Please circle any of the following problems which you have now or have had in the past :

Sleep Apnea	Gastric Band Surgery (Lap Band)	Pulmonary Embolism
Heart Disease	Gastric Bypass	Clotting Problems
Heart Attack	Gastric Sleeve	Blood Diseases
Heart Murmur	Emphysema	Anemia
Heart Bypass Surgery	Chronic cough/Bronchitis	Easy Bruising
Heart Stents	Tuberculosis	Radiation Therapy
Other Heart Surgery	Asthma/Pneumonia	Chemotherapy
Artificial Heart Valve	Vision Loss	Seizure Disorder
Pacemaker/Defibrillator	Sinus Problems	Fainting/Dizzy Spells
Angina (chest pain)	Kidney Problems	Artificial Joints
High Blood Pressure	Stomach Ulcers	Orthopedic Hardware
Stroke	Diabetes	Excessive Bleedings
Cancer	Thyroid Disease	Psychiatric Treatment
Glaucoma	Hepatitis A B or C	Blood Transfusions
Arthritis	Liver Disease	HIV or AIDS
Neck problems	Jaundice	Cold Sores

Other : _____

_____

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PATIENT INFORMATION FORM (continued)

Do you have any personal or family history of unexpected death(s) following general anesthesia or exercise; a family or personal history of Malignant Hyperthermia, a muscle or neuromuscular disorder, high temperature following exercise; a personal history of muscle spasm, dark or chocolate colored urine, or unanticipated fever immediately following anesthesia or extreme exercise?
[ ] No [ ] Yes Explain if yes_____

Other Physicians seen in last 5 years :

Name : _____

Name : _____

Name : _____

Please list ALL previous surgeries, including plastic/cosmetic surgeries

Year	Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you smoke ? [ ] No [ ] Yes, if so, how much ? _____

Did smoke previously ? [ ] No [ ] Yes , if so, how much ? _____

How much alcohol do you consume ? _____

Any other drugs, legal or otherwise ? (please specify) ? _____

Have any blood relatives had any of the following?	YES	NO	
Clotting problems (clots in legs, embolism to lungs)	[ ]	[ ]	_____
Bleeding Tendencies	[ ]	[ ]	_____
Abnormal reaction to anesthesia	[ ]	[ ]	_____
Heart disease	[ ]	[ ]	_____
High blood pressure	[ ]	[ ]	_____
Cancer (if yes, specify)	[ ]	[ ]	_____

In the past year have you taken prednisone, cortisone or ACTH ? [ ] No [ ] Yes

In the past year have you taken Accutane ? [ ] No [ ] Yes

Please list, with dosages, ALL medications, including birth control, aspirin, and any over the counter medications, vitamins or supplements you take : _____

_____

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature _____ **Date** _____

Patient Name (Print) _____

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PATIENT INFORMATION FORM (Consent to communicate)

Please indicate the method that you prefer us to communicate with you :

[ ] Home Phone

[ ] Work Phone

[ ] Cell Phone

[ ] USPS mail

If OK to leave voice message with another person, please list them : _____

_____

_____

EMERGENCY CONTACT :

Name : _____

Relationship : (check one) [ ] Spouse [ ] Parent/Guardian [ ] Other _____

Home Ph : (_____) _____ Cell Ph : (_____) _____ Work Ph : (_____) _____

"Federal law prohibits this practice from sending you texts or email which are unencrypted or "unsecure." However, many patients find it convenient to communicate with our office by traditional text and/or email. Those modes of communication are generally not considered "secure." Some patients appreciate the tradeoff between ease of use / convenience and security. We want to accommodate your preferences. If you would like to communicate with us by "unsecure" text or email, please confirm below by providing your authorization. We will keep your preferences in force with no current expiration date until we learn otherwise. Obviously, you can change your mind at any point down the road. Just let us know in writing so we can stay updated with your preference(s). If messages are sent through such channels, they may no longer be protected by HIPAA. Finally, whether or not you decide to use email or text messaging, your choice will have no impact on our decision to treat you. We are here for you. I authorize for the practice to communicate with me by "unsecure" email. I authorize the practice to communicate with me by "unsecure" text). In addition, I also agree and consent to receipt of advertising/marketing messages from the practice by text messaging to the number I provided above. Such text messages will be made using automated technology. Standard message and data rates may apply. To stop any further advertising or marketing text messages, reply STOP to any received message and any such messages will cease or send written confirmation to the practice.

Signature:_____ **Date:**_____

Text appt. reminders – list mobile carrier : _____

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PATIENT INFORMATION FORM-HIPAA

Patient Name: _____

Last First MI

The Health Insurance Portability and Accountability Act ("HIPAA") provides safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003. Many of the policies are minimum standards for the standards for this practice. This form is "friendly version. A more complete detailed version is available in the office.

What this is all about: Specifically there are rules and restrictions as to who may see or be notified of your Protected Health Information ("PHI"). These restrictions do not include the normal exchange of information necessary to provide you with our office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with the quality professional service and care. Additional information is available from the U.S. Dept. of Health and Human Services (www.hhs.gov).

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing areas such as front office, examination room, etc. Those records will not bea available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do so by telephone, e-mail, U.S. mail, or by any other means convenient for the practice and/or as requested by you. We may send you other communications informing of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must abide by the confidentiality rules of HIPPA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies, or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods and services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPPA Information Form and any subsequent changes of office policy. I understand that this consent shall remain in force from this time forward.

Signature of Insured/Guardian: _____ **Date :** _____

Patient Name (Print): _____

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PATIENT INFORMATION-NO SHOW FEE

It is the policy of this office to remind patients of their appointments. We may do so by text, telephone, e-mail, or by any other means convenient for the practice and/or as requested by you. We may send you other communications informing of changes to office policy and new technology that you might find valuable or informative.

Non-surgical treatments/services are booked to allow enough time for your treatment including numbing if necessary. The time is allotted entirely to you as the patient. Cancellations happen. But it is very difficult to fill a spot with little notice. The cancellation policy stands as follows:

When you are scheduled for a treatment/service, you will be asked to provide a credit card. We will be charging your card $1 to confirm it is an active card. That will be credited to your bill. If you do not cancel with 24 hours notice you will be assessed a fee of 50% of the treatment/service. If you are scheduled for a free consultation with any provider and do not cancel with 24 hours notice your cancel fee will be $100.

Signature: _____ **Date :** _____

Patient Name (Print): _____

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