GREENWICH PLASTIC SURGERY, LLC

Cosmetic, Reconstructive, and Hand Surgery

Steven A. Fern, M.D., F.A.C.S.: Director

PATIENT INFORMATION

Patient Name:	
Address:	Home Phone #:
City, State, Zip Code:	Home Fax #:
Email Address:	Mobile Phone #:
Date of Birth:	Birth Sex: Male Female
Age:	Legal Sex: Male Female
Occupation:	Gender Identity: Male Female Other
Civil Status: (Circle) Single Married Divorced Widow/Widower	
Parent or Legal Guardian Name(s) (if patient is a minor)/ Relationship to patient:	
Address (if different from above):	Home Phone #:
City, State, Zip Code:	Home Fax #:
Email Address:	Mobile Phone #:
Employer:	Job Title:
Employer Address:	Work Phone #:
City, State, Zip Code:	Work Fax #:
Primary Care Physician:	
Address:	Office Phone #:
City, State, Zip Code:	Office Fax #:
Referring Physician (if any):	
Address:	Office Phone #:
City, State, Zip Code:	Office Fax #:
Preferred Method of Contact: (Circle) Email Mobile # Home # Work # Other	
How did you hear about our practice?	

_____

Patient/Parent or Legal Guardian (if patient is a minor)-Printed Name/Signature: Date:

166 East 61st Street New York, NY 10065 Tel: (212) 207-9200 Fax: (212) 207-9252
2 ½ Dearfield Drive Greenwich, CT 06831 Tel: (203) 629-1900 Fax: (203) 869-5915
www.drfern.com

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MEDICAL HISTORY FORM

Patient Name:	Date:
Reason for Visit:	

YES	NO	Are you under the care of another physician(s)?
		If yes, for what condition(s)?
		Name, Address & phone number of physician(s):
YES	NO	Have you ever had surgery?
		If yes, please specify:
YES	NO	Are you taking any medications?
		If yes, please give name(s):
YES	NO	Do you smoke? If yes, how much?
YES	NO	Do you vape? If yes, how much?
YES	NO	Do you drink? If yes, how much?

Have you ever had? (please circle):

Yes	No	Heart trouble, stroke, etc.	Yes	No	Abnormal blood pressure
Yes	No	Bleeding Problems	Yes	No	Tuberculosis
Yes	No	Hepatitis or Jaundice	Yes	No	Cancer or Tumor
Yes	No	Diabetes	Yes	No	Thyroid Disorder
Yes	No	Hay Fever/Seasonal Allergies	Yes	No	Asthma

Other Health Problems:_____

Circle any medications or products that you are allergic to:

Aspirin Codeine Demerol Local Anesthetics Penicillin

Latex Materials Surgical Tape Neosporin Bacitracin Other:_____

_____

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PRIMARY INSURANCE

Insurance Company:	
Address:	Phone #:
Member ID No:	
Group No:	
Subscriber Name (if not self):	Phone #:
Relationship to Patient:	Date of Birth:

SECONDAY INSURANCE

Insurance Company:	
Address:	Phone #:
Member ID No:	
Group No:	
Subscriber Name (if not self):	Phone #:
Relationship to Patient:	Date of Birth:

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FINANCIAL POLICIES

I, hereby, acknowledge that Dr. Steven A. Fern is an out-of-network provider and that the financial policies of the office have been reviewed with me. I understand that payment is required at the time that services are rendered, and that Dr. Fern's office staff will submit a detailed medical claim to my insurance company on my behalf. I, hereby, authorize the release of any information necessary to process claims on my behalf and authorize the use of this signature on all insurance claim forms.

I understand that providing health insurance information is not a substitution for payment. I further understand that it is my responsibility to see that my medical claims are paid in full on a timely basis.

_____

Patient/Parent or Legal Guardian (if patient is a minor)- Printed Name/Signature: Date:

HIPAA PRIVACY POLICY

I, hereby, authorize the release of any medical records or reports necessary for the purpose of my treatment, or for consultation with other physicians or medical laboratories.
I authorize appropriate release of medical information for the processing of insurance claims.
I authorize the taking of clinical photographs for documentation of anatomic problems. Such photographs may be used for subsequent preoperative and or postoperative analysis, or for educational purposes. Some insurance companies may require photographic documentation for pre-certification of surgical procedures. In accordance with the Federal "Health Insurance Privacy Accountability Act" (HIPAA) regulations, I understand that my medical records will be kept in conditions of medical privacy, and that I may restrict distribution of my medical records by notifying the office in writing.
Medical records relating to my case will be maintained for seven years from the initial treatment date, and they will be destroyed, confidentially, thereafter.
I have received a copy of the office's Privacy Practice notice.

_____

Patient/Parent or Legal Guardian (if patient is a minor)-Printed Name/Signature: Date:

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CONSENT FOR SURGERY / PROCEDURE OR TREATMENT

Patient Name: _____ Date: _____

1) I hereby authorize Dr. Steven Fern and such assistants as may be selected to perform the following procedure or treatment: _____.

2). I recognize that during course of the operation and medical treatment or anesthesia, unforeseen conditions may necessitate different procedures than those above. I, therefore, authorize the above physician and assistants or designees to perform such other procedures that are in the exercise of his or her professional judgement necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my physician at the time the procedure has begun.

3). I consent to the administration of such anesthetics considered necessary or advisable. I understand that all forms of anesthesia involve risk and the possibility of complications, injury and sometimes death.

4). I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.

I consent to the treatment or procedure and the above listed items. I am satisfied with the explanation and my questions have been answered.

_____ _____

Patient or Person Authorized to Sign for Patient Date

Witness: _____

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