

RiverSong Plastic Surgery
Timeless Faces

Patient Registration

Update 3/13/08

Last Name _____ First Name _____ MI _____

Street _____ P.O. Box _____ City _____ ST _____ ZIP _____

Phone _____ Cell Phone _____ E-Mail _____

DOB _____ Social Security # _____ Sex: M or F

Employer _____ Work Number _____ Occupation _____

Address _____

Marital Status: S M D W SEP Spouse Name _____ DOB _____

In case of emergency contact name _____

Emergency phone contact _____

May we discuss your medical care? Yes No

Any restrictions to what we may disclose _____

Pharmacy name _____ Phone _____

Insurance Information

Primary Care Physician _____ Phone _____

Insurance Name _____ ID # _____ Group _____

Subscriber's Name _____ DOB _____ SS # _____

Employer _____ Phone _____

Responsible Party (for minor's only) _____

Assignment & Release

I authorize the release of any information including diagnosis and records of any treatment in order to carry out treatment, payment and health care operation. A notice of my privacy rights has been offered to me. I authorize and request my insurance company to pay directly to RiverSong Plastic Surgery. I understand that my insurance carrier may pay less or none of the services I am receiving. I agree to be responsible for payment in full of services rendered on my behalf or my dependents. I also understand that if my insurance requires referrals I am responsible for getting these prior to my visits, otherwise full payment will be paid at the time of visit.

Signature _____ Date _____

PREVIOUS SURGERY:

Please list any previous surgeries you may have had.

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

FAMILY HISTORY:

Do any of your family members have any of the following:

	Yes	No		Yes	No		Yes	No
Breast Cancer			Diabetes			Heart Disease		
Melanoma			Stroke			Kidney Disease		
Other Cancer			High Blood Pressure			Depression		
Bleeding problems			Anesthesia problems			Blood clot problems		
Arterial Disease			Varicose veins					

MEDICATIONS:

Please list any prescription, non-prescription, and herbal medications you are taking. If you have a list, please provide it for us to copy.

- | | |
|----------|-----------|
| 1. _____ | 7. _____ |
| 2. _____ | 8. _____ |
| 3. _____ | 9. _____ |
| 4. _____ | 10. _____ |
| 5. _____ | 11. _____ |
| 6. _____ | 12. _____ |

SOCIAL HISTORY:

Do you Smoke? Yes _____ No _____ If so, how many packs per day? _____

If you smoked in the past, when did you quit? _____

On average, how many alcoholic drinks do you have per week? _____

Have you had problems with substance abuse? _____ if so, please describe _____

HT _____ WT _____

RiverSong Plastic Surgery
21 Highland Avenue
Suite 3-4A
Newburyport, MA 01950

AUTHORIZATION TO TAKE PHOTOGRAPHS

PLEASE CHECK ONE:

- I DO HEREBY AUTHORIZE MICHELE T. SASMOR, MD AND/OR MICHAEL F. KUTKA, MD TO TAKE PHOTOGRAPHS OF ME AND USE THEM AS AN AID IN MY TREATMENT.

- I DO NOT CONSENT TO PHOTOGRAPHS BEING TAKEN OF ME.

SIGNATURE

DATE

SIGNING THIS SECTION IS OPTIONAL:

THE UNDERSIGNED HEREBY AUTHORIZES FOR MICHELE T. SASMOR, M.D. AND/OR MICHAEL KUTKA, MD TO USE MY PHOTOGRAPHS FOR PATIENT EDUCATION UNDERSTANDING MY IDENTITY WILL BE KEPT CONFIDENTIAL.

SIGNATURE

DATE

RiverSong Plastic Surgery & Timeless Faces

Notice of Privacy Practices Patient acknowledgement

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization. A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
 - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
 - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
 - The right to receive confidential communications of protected health information.
 - The right to inspect and copy protected health information.
 - The right to amend protected health information.
 - The right to receive an accounting of disclosures of protected health information.
 - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

Name: _____

Date: _____

Welcome to RiverSong Plastic Surgery & Timeless Faces Advanced Skin Care Clinic

Please take a few moments to let us know how you became acquainted with our office.
You may check as many boxes as appropriate.

Which Doctor or Esthetician are you seeing?

Circle One: **Dr. Sasmor** **Dr. Kutka** **Anne Connolly**

- Referred by another physician,
By whom? _____
- Referred by a friend or family member,
By whom? _____
- Referred by a Newspaper Advertisement
Which one? _____
- Post Card
- Coupons
- Referred by internet
- Referred by the Yellow Pages
- Seminar @ _____
- Referred by other source, please elaborate _____

- Cosmetic Patient
- Skincare/Estheticians

Thank you for completing this short survey. We hope that your time with us is informative and that it fulfills your expectations.

Offices: AJH – 21 Highland Avenue – Suite 3-4A – Newburyport, MA 01950 – 978-462-8300 – Fax 978-462-8301

MVH – 140 Lincoln Avenue – Haverhill, MA 01813 – 978-521-7600 – Fax 978-521-7176