21 Highland Avenue, Suite 3-4A
Newburyport, MA 01950
978-462-8300

Patient Registration

Last Name:	First Name:	MI
Address, City, State ZIP		
Phone #	Cell Phone #	E-Mail
Date of Birth	Social Security #	Sex: M or F

Employer Information

Employer Name	Work Number #	Occupation
Employer Address, City, State ZIP		

Marital Status S D W Sep M	Spouse Name & Date of Birth
In case of emergency contact name	Contact phone #
May we discuss your medical care: ❑ No ❑ Yes - Any restrictions to what we may disclose?	
Pharmacy Name	Pharmacy Phone #

Insurance Information

Primary Care Physician	Physician Phone #	
Insurance Name	ID #	Group #
Subscriber Name:	Date of Birth	Social Security #
Subscribers Employer	Subscribers Employer Phone #	
Responsible Party (for minors 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 privacy rights updated on 7/23/13 is available 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. RiverSong Plastic Surgery may contact me using the above contact information.

Signature: ____ Date: ______________________

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Medical History

Name:	Date of Birth/Age:	Today's Date:
Reason for this visit today?		

Are you allergic to any of the following?
❒ Latex ❒ Novocaine ❒ Iodine ❒ Penicillin ❒ Codeine ❒ Aspirin ❒ Adhesive Tape

If yes to any of the above, what reaction do you have?
____

Do you have any other allergies/sensitivities? ❒No ❒Yes - explain: ___________________________

____

Medical Information: Have you ever had, or been treated for any of the following?

Cardiac
- ❒ High Blood Pressure
- ❒ High Cholesterol
- ❒ Chest Pain/Angina
- ❒ Heart Attack
- ❒ Heart Failure
- ❒ Stents/Cardiac Surgery
- ❒ Taking Coumadin
- ❒ Taking Plavix
- ❒ Bleeding or Bruising
- ❒ Irregular Heart Beat
- ❒ Pacemaker
- ❒ Implanted Defibrillator

Vascular
- ❒ Stroke
- ❒ Poor circulation legs
- ❒ Varicose Veins
- ❒ Swollen Legs
- ❒ Blood Clots in Legs
- ❒ Blood Clots in Lungs
- ❒ Leg Ulcers

Eye, Ear, Nose, Throat
- ❒ Glaucoma
- ❒ Visual Problems
- ❒ Dry Eyes
- ❒ Sinus Problems
- ❒ Environmental Allergies
- ❒ Hearing Problems

Respiratory
- ❒ Asthma
- ❒ Emphysema/COPD
- ❒ Sleep Apnea/CPap
- ❒ Anesthesia Problems
- ❒ Short of Breath

Endocrine
- ❒ Diabetes:
  - ❒ Diet Controlled
  - ❒ Oral Med Controlled
  - ❒ Insulin Controlled
- ❒ Diabetic Eye Problems
- ❒ Diabetic Kidney Problems
- ❒ Numbness in Feet and Legs
- ❒ Thyroid Disease

Gastrointestinal
- ❒ Acid Reflux (GERD)
- ❒ Ulcers
- ❒ Stomach Problems
- ❒ Black/Bloody Stool
- ❒ Crohn's/Ulcerative Colitis
- ❒ Gall Stones
- ❒ Gastric Bypass
- ❒ Hepatitis/Liver Disease

Genitourinary
- ❒ Kidney Stones
- ❒ Chronic Bladder Infections
- ❒ Hysterectomy
- ❒ Prostate Problems

Breast
- ❒ Breast Cancer
- ❒ Breast Infections
- ❒ Nipple Discharge
- ❒ Breast Pain
- ❒ Breast Implants

Skin
- ❒ Skin Cancer
- ❒ Melanoma
- ❒ Previous Mohs Surgery
- ❒ History MRSA
- ❒ Rosacea
- ❒ Healing Problems
- ❒ Previous Burn
- ❒ Psoriasis

Blood/Lymph/Immune
- ❒ Chronic Anemia
- ❒ Bleeding/Bruising Problems
- ❒ HIV/AIDS
- ❒ Lupus
- ❒ Rheumatoid Arthritis
- ❒ Scleroderma
- ❒ Lyme Disease
- ❒ On Prednisone

Musculoskeletal
- ❒ Osteoarthritis
- ❒ Back Pain
- ❒ Back Surgery
- ❒ Muscle Disease
- ❒ Fibromyalgia

Neurological
- ❒ Headaches/Migraines
- ❒ Seizures
- ❒ Depression/Anxiety
- ❒ Psychiatric Care
- ❒ MS/Motor Neuron Disease

Any other Medical Problems:
____
____
____

Any Cancer, please list:
____
____
____

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Medical History

Name:	**Date of Birth/Age:**	**Today's Date:**

Previous Surgery:
Please list any previous surgeries you may have had:

____

____

____

____

____

Medications:
Please list any prescription, non-prescription and herbal mediations 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.

Family History
Mark if any family member has the following and how they are related:

Relation

❒ Skin Cancer _________________________________
❒ Melanoma___________________________________
❒ Breast Cancer _______________________________
❒ Other Cancer _______________________________
❒ Diabetes ___________________________________
❒ Stroke/TIA__________________________________

Relation

❒ High Blood Pressure _________________________
❒ Heart Attack, Stents or Cardiac Surgery_________
❒ Artery Disease of the legs_____________________
❒ Varicose Veins_______________________________
❒ Blood clotting or Bleeding Problems ___________
❒ Anesthesia Problems ________________________

Social History

❒ Single ❒ Married ❒ Divorced ❒ Widow/Widower ❒ Children, how many _____________

Occupation or Primary Activity: ____

Do you Smoke ❒ No ❒ Yes, 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? ❒ No ❒ Yes, please describe __________________________

____

Height:___________________________ Weight: ______________________

Name:	Date of Birth/Age:	Today's Date:

Authorization to Take Photographs/Record Release

PLEASE CHECK ONE:

❑ Yes ❑ No

I do hereby authorize Michele T. Sasmor, MD to take photographs of me and use them as an aid in my treatment. Photographs may be taken in the office, wound center, operating room, or inpatient.

PLEASE CHECK ONE:

❑ Yes ❑ No

I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for the use in examination, testing, credentialing and/or certifying purposes by the American Board of Plastic Surgery, Inc.

____ _________________________________

Patient Name (please Print*)* *Patient Date of Birth*

____ _________________________________

Patient Signature *Date/Time*

SIGNING THIS SECTION IS OPTIONAL

The undersigned hereby authorizes Michele T. Sasmor, MD to use my photographs for patient education understanding steps will be taken to prevent my identity from being disclosed.

____ _________________________________

Patient Signature *Date*

____ _________________________________

Witness Signature *Date*

Name:	Date of Birth/Age:	Today's Date:

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

Who are you seeing today? Dr. Sasmor __ Anne Connolly __ Stefanie Magnant __ Linda Wood__

How did you hear of us?

- ❒ A physician, by whom?____
- ❒ A friend or family member, by whom? ____
- ❒ Web Site
- ❒ Internet
- ❒ Facebook
- ❒ Email Blast
- ❒ Post Card
- ❒ Magazine
- ❒ Seminar, where? ____
- ❒ Referred by other source, please elaborate ____

____

____

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