BUCKS COUNTY PLASTIC SURGERY CENTER, P.C.

Feel Beautiful Again...

RJS / BL

PATIENT REGISTRATION/INSURANCE INFORMATION

Last Name _____ First Name _____ Initial _____

Address _____ City _____ State _____ Zip _____

Telephone # _____ Cell # _____ Work # _____

Sex: M ____ F ____ E-Mail Address _____

Date of Birth _____ SS# _____ Marital Status _____

Spouse Last _____ First _____ DOB _____ SS# _____

In Case of an Emergency, please contact _____ ***Phone #*** _____

Whom may we thank for referring you to our practice? _____

If a physician, please list address _____

EMPLOYMENT INFORMATION

Patient Employer _____

Street Address _____

City _____ State _____ Zip _____

Phone # _____

EMPLOYMENT INFORMATION

Spouse Employer _____

Street Address _____

City _____ State _____ Zip _____

Phone # _____

INSURANCE INFORMATION

Primary Carrier _____

Street Address _____

City _____ State _____ Zip _____

Phone # _____

ID # _____ Group # _____

Name of Policyholder _____

INSURANCE INFORMATION

Secondary Carrier _____

Street Address _____

City _____ State _____ Zip _____

Phone # _____

ID # _____ Group # _____

Name of Policyholder _____

PRIMARY CARE PHYSICIAN

Group Practice Name _____

Street Address _____

City _____ State _____ Zip _____

Phone # _____ Fax # _____

May we leave a detailed message on home or cell phone?
Yes ☐ No ☐

May we send information to your home address?
Yes ☐ No ☐

I certify that the information given is accurate and correct. I am fully responsible for all charges not covered by any insurance company. I authorize payment of medical benefits directly to the treating physician(s) and also authorize the release of any medical information necessary to process insurance claims. I further agree that this authorization will cover all medical services rendered until such authorization is revoked by me.

DATE: _____

SIGNATURE: _____

(Patient or Power of Attorney)

Are you interested in financing your cosmetic procedure?
Yes ☐ No ☐

ROBERT J. SKALICKY, D.O. • BENJAMIN LAM, D.O., F.A.C.O.S.

104 PHEASANT RUN, BLDG A, SUITE 123, NEWTOWN, PA 18940

BUCKS COUNTY PLASTIC SURGERY CENTER, P.C.

Feel Beautiful Again...

MEDICAL HISTORY

Date _____ Physician _____

Last Name _____ First Name _____ Initial _____

DOB _____ Age _____ Height _____ Weight _____

Allergies? Yes____ No ____ If yes, list all _____

Medication taking now _____ Past Surgeries _____ Year _____

_____ _____ Year _____

_____ _____ Year _____

Do you take aspirin or blood thinners? Yes____ No____ How often?_____

Do you take diet medication/herbal products? Yes____ No____ How often?_____

Please check Yes or No:	Yes	No		Yes	No
Angina	☐	☐	GI Problems/Ulcers	☐	☐
Diabetes	☐	☐	TB/Aids	☐	☐
Thyroid	☐	☐	Seizures	☐	☐
Eye Problems	☐	☐	Breast Cancer (other)	☐	☐
Vascular Disease	☐	☐	Blackouts	☐	☐
Received Blood Transfusion	☐	☐	Bleeding Disorders	☐	☐
Hypertension	☐	☐	Anesthesia Problems	☐	☐
Heart Attack/Stroke	☐	☐	Drug Abuse	☐	☐
Arthritis	☐	☐	Alcohol Abuse	☐	☐
Liver Problems	☐	☐	Tobacco Use	☐	☐
Hepatitis *(list type below)*	☐	☐	Kidney Disease	☐	☐
_____			Other conditions_____		
Asthma/Lung Disease	☐	☐	_____		

Patient Signature: _____ Nurse Signature:_____

ROBERT J. SKALICKY, D.O. • BENJAMIN LAM, D.O., F.A.C.O.S.

104 PHEASANT RUN, BLDG A, SUITE 123, NEWTOWN, PA 18940

PRIVACY PRACTICES ACKNOWLEDGEMENT

Your Rights. Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You have the right to use another Healthcare Professional.
You have the right to request confidential communications from us by alternative means or at an alternative location.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.
You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Patient's Name _____ Signature _____ Date _____
(Please print)

Parent/Guardian *(if patient is under 18)*

Name _____ Signature _____ Date _____
(Please print)

I hereby give my permission for Bucks County Plastic Surgery Center, P.C. to disclose information regarding my treatment to:

Spouse: _____ Son/Daughter: _____

Parents: _____

Other: _____

Physician: _____