Charles J. Gaudet, M.D., FACS
Piscataqua Plastic Surgery and Skin Care

PATIENT REGISTRATION AND CONSENT FOR TREATMENT FORM

PATIENT INFORMATION

MR/MRS/MISS PREFERRED FIRST NAME TITLE (_____) HOME PHONE

FIRST NAME M.I. LAST NAME (_____) WORK PHONE

ADDRESS APT# (_____) CELL PHONE

CITY STATE ZIP + 4 Digit Extension

_____ _____ MALE ___ FEMALE ___ OTHER ___

BIRTH DATE AGE

Email address: _____

YES, I would like to receive emails, filled with coupons, articles and seasonal information from Piscataqua Plastic Surgery and Skin Care

EMERGENCY CONTACT

FIRST NAME LAST NAME

RELATIONSHIP

(_____) HOME PHONE

(_____) WORK PHONE

(_____) CELL PHONE

SPOUSE

FIRST NAME LAST NAME

SPOUSE'S EMPLOYER

(_____) SPOUSE'S PHONE

(_____) WORK PHONE

(_____) CELL PHONE

PATIENT EMPLOYMENT INFORMATION

FULL TIME FULL TIME STUDENT RETIRED
PART TIME PART TIME STUDENT OTHER

OCCUPATION

COMPANY OR SCHOOL

ADDRESS

CITY STATE ZIP

WORK PHONE

HOW DID YOU HEAR ABOUT US

PHYSICIAN PATIENT FAMILY MEMBER
FRIEND WEBSITE OTHER

FIRST NAME LAST NAME TITLE

ADDRESS

CITY STATE ZIP

WEBSITE

OTHER

PISCATAQUA PLASTIC SURGERY AND SKIN CARE **(603) 431-5488** **Health Information** as of _____

Confidential Record: The information contained here will not be released unless you authorize us to do so. Please answer all questions as accurately and completely as possible to assist us in addressing the health needs that brought you here today.

Patient Name: _____ **Reason for visit:** _____

Age: _____ Height: _____ Feet: _____ Inches ____ Weight: _____

PCP Name: _____ **Referring Doctor:** _____

List all Surgeries (Hospitalization and the Date of Occurrence):

List any Serious Illnesses and/or Accidents:

Do you have or have you had any of the following: (circle for each, give date occurred if Yes)

Aids / HIV	No	Yes	Epilepsy / Seizures	No	Yes	Kidney Problems	No	Yes
Arthritis	No	Yes	Facial Pain	No	Yes	Pneumonia	No	Yes
Asthma	No	Yes	Fever Blisters	No	Yes	Sinus Problems / Infections	No	Yes
Bronchitis	No	Yes	Goiter / Thyroid	No	Yes	Stroke	No	Yes
Cancer	No	Yes	Hay Fever / Allergies	No	Yes	Tonsillitis	No	Yes
Depression	No	Yes	Headaches / Migraine	No	Yes	Tuberculosis	No	Yes
Diabetics	No	Yes	Heart Trouble	No	Yes	Ulcers	No	Yes
Dizziness / Vertigo	No	Yes	Hepatitis	No	Yes	MRSA	No	Yes
Ear Infection	No	Yes	High Blood Pressure	No	Yes	Pregnancies: #_____	No	Yes

Do you smoke?	No	Yes	If yes how much?		Pack(s)/day	How long?	__	Years
Do you drink alcohol?	No	Yes	If yes how much?		How often?	_____		
Do you use recreational drugs?	No	Yes	If yes, describe:	_____				
Do you have bleeding or bruising problems?	No	Yes	If yes, describe:	_____				
Do you have problems with scarring?	No	Yes	If yes, describe:	_____				
Do you have any history of problems with anesthesia?	No	Yes	If yes, describe:	_____				

List the name of all medications & supplements you are presently taking or have taken within the last month. Please include the name of the drug, dosage and frequency.

List ALL drug, food and/or latex allergies.

The above information is accurate and complete to the best of my knowledge.

Signature: _____ **Date:** _____

Charles J. Gaudet, M.D., FACS
Piscataqua Plastic Surgery and Skin Care
330 Borthwick Avenue, Suite 206
Portsmouth, NH 03801
603-431-5488

Notice of Privacy Practices

PLEASE READ AND SIGN FORM PROVIDED TO YOU

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IF YOU WISH FOR A COPY OF THIS FORM TO TAKE HOME, WE CAN EASILY PROVIDE ONE FOR YOU.

Uses and disclosures of your health information

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and/or providing treatment.

Payment: Your health information may be used to seek payment from your insurance carrier(s), other sources of coverage (for example: automobile insurer) or from credit card companies that you have used to pay for services.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of this practice. For example, information on the services you received may be used to support budgeting, financial reporting, evaluation, and quality control.

Law Enforcement: Your health information may be disclosed to law enforcement agencies in the conduct of government audit and inspections, in order to facilitate a law enforcement investigation and/or to comply with government-mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, this practice is required to report certain communicable diseases to state's public health departments.

Patient Contact: Your health information will be used by the practice in order to notify you of changes in schedule, which may affect your appointment date or time.

Other uses and disclosures that REQUIRE your authorization!!

Disclosures of your health information or its use for any purpose other than those listed above, requires your written authorization. If you change your mind at any time, and wish to revoke your authorization, you may simply do so by notifying the practice in writing. Your decision to revoke your authorization will NOT apply to any use or disclosure of information that occurred prior to the practice's receipt of your notice to revoke authorization.

Your Individual Rights: *You have certain rights under federal privacy standards which include the right to:*

- Request restrictions on the use and disclosure of your protected health information.
- Receive confidential communications concerning your medical condition and treatment.
- Inspect and copy your protected health information.
- Receive an accounting of how and to whom your protected health information has been disclosed.
- Receive a printed copy of this notice.
- Amend or submit corrections to your protected health information.

Duties of the Practice:

The practice is required by law to maintain the privacy of your protected health information, to provide you with notice of privacy practices, and to abide by the policies and practices as outlined in this notice.

Right to Amend Privacy Practices:

The practice reserves the right, as permitted by law, to amend or modify our privacy policies and practices as required by changes in federal and state laws and regulations. Upon request, the practice will provide you with the most recently revised notice. The revised policies and practices will apply to all protected health information that the practice maintains.

Patient Request to Inspect Protected Health Information:

You may inspect or copy the protected health information that the practice maintains on your behalf. As permitted by federal regulation, the practice requires that any request to inspect or copy protected health information be submitted in writing to the office. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.
Please be advised that there will be a fee for any copies obtained.

Complaints:

If you wish to submit a comment, complaint, or question about the Practice's privacy policies and/or practices or have any concerns that your privacy rights have been violated, please send a letter to:

PRACTICE MANAGER
Piscataqua Plastic Surgery and Skin Care
330 Borthwick Avenue, Suite 206
Portsmouth, NH 03801

PATIENT ACKNOWLEDGEMENT

By signing this form, you are acknowledging that you have been given the opportunity to read the entire NOTICE OF PRIVACY PRACTICES and, if you so desire, been given a copy of these practices to keep for you records.

I have received a copy of the Notice of Privacy Practices for Piscataqua Plastic Surgery and Skin Care:

_____ _____
Patient Signature, if minor, patient representative Date:

In the event that no signature is obtained, a staff member of the practice, hereby states that the reason that the patient's signature was not obtained was because:

- The patient was undergoing emergency treatment
- The patient declined to sign the acknowledgment
- Other _____

_____ _____
Signature of Staff Person: Date: