

MARC S. ZIMBLER, MD, FACS
FACIAL PLASTIC & RECONSTRUCTIVE SURGERY

Patient Registration

Patient Information

Last Name: _____ First Name: _____

Date: ____/____/____ Age: _____ Gender: M F Marital status: S M W D

SS# : _____ - _____ - _____ Birth date: ____/____/____

Address: _____

City: _____ State: _____ Zip code: _____

Home phone: _____ Cell phone: _____

Emergency Contact: _____ Phone Number: _____

Email Contact: _____

Primary Physician Name: _____

Who should we thank for referring you? _____

Employer Information

Occupation: _____ Work Number: _____

Company Name: _____

Address: _____

Medical Insurance Information

Primary Insurance: _____

Relationship of insured to Guarantor: _____

Guarantor Name: _____

Secondary Insurance: _____

I hereby authorize payment directly to Dr. Marc S. Zimbler for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by my insurance, and for all services rendered on my behalf or my dependents.

I authorize Dr. Marc S. Zimbler and or any provider or supplier of services in his office to release any information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of responsible party: _____ Date: ____/____/____

Purpose of today's visit? _____

Do you have a history of the following? (Please check all that apply)

- High blood pressure:
- Mital valve prolapse:
- Heart disease or history of heart attack:
- Are you pre-treated with antibiotics by your dentist:
- Neurologic disease or history of stroke:
- Lung or respiratory disease:
- Shortness of breath or chronic cough:
- Arthritis or joint disease:
- Autoimmune disease (lupus, rheumatoid arthritis)
- Stomach ulcers or GI problems:
- Kidney disorder:
- Diabetes:
- Thyroid dysfunction:
- Dry eye, eye disease, glaucoma:
- Spinal or back disorders:
- Previous blood clots or thrombophlebitis:
- Bleeding disorder in self or family history:
- Are you taking blood thinners:
- Blood transfusions:
- Liver disorders:
- Hepatitis or cirrhosis:
- AIDS or HIV:
- Do you suspect you might be pregnant:
- Family medical history of significance: _____
- Depression or anxiety: _____
- Other psychiatric illnesses: _____
- Skin cancer: _____
- If so, was it treated surgically: _____
- Any other types of Cancer: _____
- Skin diseases; herpes, cold soars, eczema, psoriasis: _____
- Have you used Accutane in the last 12 months:
- Unusual scarring or keloid formation: _____
- Facial paralysis or Bell's palsy:
- Have you ever had a serious injury to your head, face or neck:
- Radiation therapy to the face or neck: _____
- Difficulty breathing through your nose:
- Is there a history of nasal trauma: _____
- Have you used Botox or other facial fillers within the last 12 months: _____

- History of nasal or sinus surgery: _____
- History of facial surgery: _____
- History of any other surgeries: _____

- Allergies to medications: _____
- Allergies to adhesive tape:
- Allergies to local anesthesia:
- A reaction to general anesthesia: _____
- A family history of allergies to anesthesia:

- Do you smoke: _____
- Did you ever smoke: _____
- Do you drink more than 2 alcoholic drinks per day:
- Have you ever had a problem with alcohol dependence: _____
- Have you ever had a problem with drug dependence: _____
- Do you use any "recreational drugs" with frequency: _____

Please list all medications: (include aspirin, birth control, vitamins, herbal or homeopathic medicines)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Consent for Photography

I do hereby voluntarily give consent to the taking of photographs of me under the following conditions:

1. The photographs shall be taken by my physician or by his assistant.
2. The photographs may be released to other physicians or insurance companies when necessary.
3. The photographs will be used for medical records and may be published in medical professional journals or medical books, or used for other purposes which may be deemed proper in the interest and advancement of medical knowledge, medical education - research, or patient education.
4. The photographs will not be available on the internet (unless published in professional medical journals which have on-line journal access).
5. Although I give permission to the publication and use of details concerning my case, it is specifically understood that I will not be identified by name.

Signature (Patient or Guardian)

____/____/____
Date

Notice of Privacy Practice Patient Acknowledgement

I have received and understand this practices 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 practices legal duties with respect to my health information. All forms and policies referred to in this Notice of Privacy Practice are available at the reception desk and in the waiting room.

I understand that 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 it maintains. If changes occur, this practice will provide me a revised notice upon request.

Patient Name: _____

Date of Birth: ____/____/____

Signature: _____

Today's Date: ____/____/____

Letter of Agreement

This letter of agreement acknowledges that you are aware that Dr. Zimbler is not a participator with insurance plans (except Medicare). As a courtesy, we will submit your bill directly to your insurance carrier. Any portion of the bill not covered by insurance, i.e. deductibles/co-payments, will be your responsibility.

By signing this letter you agree to send our office any payments/documents sent directly to you by your insurance carrier. If you have questions regarding your insurance plan, make sure this is discussed with our office before services are rendered.

Sign: _____

Date: ____/____/____