

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

**Patient Registration**

**Patient Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Gender: M F Marital status: S M W D

SS# : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Primary Physician Name: \_\_\_\_\_

Who should we thank for referring you? \_\_\_\_\_

Purpose of Today's Visit \_\_\_\_\_

**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: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Medical History Questionnaire

Place checks if you have any of the following medical conditions:

- Hypertension: \_\_\_\_\_
- High Cholesterol: \_\_\_\_\_
- Irregular Heart Rhythm / Atrial Fibrillation: \_\_\_\_\_
- Heart Disease / Heart Attack: \_\_\_\_\_
- Stent Placement: \_\_\_\_\_
- Mitral Valve Prolapse: \_\_\_\_\_
- Peripheral Vascular Disease / Aortic Stenosis / Aortic Aneurysm: \_\_\_\_\_
  
- Lung Disease / Asthma / Tuberculosis: \_\_\_\_\_
- Sleep Apnea: \_\_\_\_\_
  
- History of Cancer \_\_\_\_\_
- Neurologic Disease / Migraines / Stroke: \_\_\_\_\_
- Arthritis / Joint Disease: \_\_\_\_\_
- Autoimmune Disease: \_\_\_\_\_
- GI Problems / Stomach Ulcers / IBS: \_\_\_\_\_
- Kidney Disorder: \_\_\_\_\_
- Diabetes: \_\_\_\_\_
- Thyroid Dysfunction: \_\_\_\_\_
- Dry Eye / Eye Disease / Glaucoma: \_\_\_\_\_
- Spinal or Back Disorders: \_\_\_\_\_
  
- Previous Blood Clots or Thrombophlebitis: \_\_\_\_\_
- Bleeding Disorders / Anemia / Blood Disease: \_\_\_\_\_
- Are You Taking Blood Thinners: \_\_\_\_\_
- Blood Transfusions: \_\_\_\_\_
- Liver Disease: \_\_\_\_\_
- Hepatitis or Cirrhosis: \_\_\_\_\_
- AIDS or HIV: \_\_\_\_\_
  
- History of Skin Cancer: \_\_\_\_\_
- Skin Disease (Herpes, Cold Sores, Eczema, Psoriasis): \_\_\_\_\_
- Have You Used Accutane in the Last 12 Months: \_\_\_\_\_
- Unusual Scarring or Keloid Formation: \_\_\_\_\_
- Facial Paralysis or Bell's Palsy \_\_\_\_\_
- Radiation Therapy to the Head or Neck: \_\_\_\_\_
- Have You Ever Had a Serious Injury To Your Head, Face or Neck: \_\_\_\_\_
- Is There a History of Nasal Trauma: \_\_\_\_\_
- Difficulty Breathing Through Your Nose / Sinusitis: \_\_\_\_\_
  
- Depression or Anxiety: \_\_\_\_\_
- Other Psychiatric Illness: \_\_\_\_\_
- Family Medical History of Significance: \_\_\_\_\_
- Do You Suspect You Might Be Pregnant: \_\_\_\_\_
- Are You Pre-treated With Antibiotics By Your Dentist: \_\_\_\_\_
- Other Medical Conditions (Please Elaborate): \_\_\_\_\_

Place checks if you have any of the following medical conditions:

Past Surgical History:

- \_\_\_\_\_ Have you used Botox or other facial fillers within the last 12 months: \_\_\_\_\_
- \_\_\_\_\_ History of facial cosmetic surgery (nose / eyelid / facelift): \_\_\_\_\_
- \_\_\_\_\_ History of functional nasal or sinus injury: \_\_\_\_\_
- \_\_\_\_\_ History of any other surgeries: \_\_\_\_\_

Allergies:

- \_\_\_\_\_ Allergies to medications: \_\_\_\_\_
- \_\_\_\_\_ Allergies to adhesive tape: \_\_\_\_\_
- \_\_\_\_\_ Allergies to local anesthesia / Lidocaine: \_\_\_\_\_
- \_\_\_\_\_ Allergies or family history of allergy to general anesthesia: \_\_\_\_\_
- \_\_\_\_\_ Other allergies: \_\_\_\_\_

Social History:

- \_\_\_\_\_ Do you currently smoke: \_\_\_\_\_
- \_\_\_\_\_ Have you ever smoked in the past: \_\_\_\_\_
- \_\_\_\_\_ 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. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

**Consent for Photography**

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

1. The photographs may be released to other physicians or insurance companies when necessary.
2. 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.
3. **The photographs will not be available on the internet** (unless published in professional medical journals which have on-line journal access).
4. 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 Regarding Medical Insurance

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: \_\_\_\_/\_\_\_\_/\_\_\_\_