

MARC 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: _____

Would You Like to Receive Periodic Emails About New Technologies or Upcoming Events? Yes No

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. Zimble 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. Zimble 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 Blot 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. _____ |

Notice of Privacy Practice Patient Acknowledgement

I have received and understand this practice's 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 practice's legal duties with respect to my health information. All forms and policies referred to in this Notice of Privacy Practices 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. 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: ____/____/____