WESTFIELD PLASTIC SURGERY - PATIENT REGISTRATION FORM

DATE ________________

PATIENT INFORMATION

PATIENT NAME ____ DATE OF BIRTH ____________________
First Middle Initial Last

SS# ______________________ AGE __________ SEX ___________ **PRIMARY CARE PHYSICIAN** _________________________

HOME ADDRESS ____
Street Address City State Zip

HOME PHONE _______________________ WORK PHONE _______________________ CELL PHONE _______________________

EMAIL ADDRESS ____

EMERGENCY CONTACT ____
Name Phone # Relationship

EMPLOYER ____
Name Street Address City State Zip Phone #

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Self Employed

IS YOUR VISIT TODAY THE RESULT OF AN ACCIDENT? ☐ Yes ☐ No IF YES, WHAT WAS THE DATE OF YOUR INJURY?______________________________

(POLICY HOLDER) PRIMARY INSURANCE INFORMATION

INSURED'S NAME ________________________________ DATE OF BIRTH ________________ SS# ______________________

INSURANCE COMPANY NAME _______________________ (____ **DOES YOUR INSURANCE CARD HAVE "REFERRALS REQUIRED" printed on the Front?)**

WCOMP CASE MANAGER NAME: ____ PHONE NUMBER: ______________________

A. **Notice of Privacy Practices**. The policies and procedures of Westfield Plastic Surgery are designed to comply with the Health Insurance Portability and Accountability Act of 1996. I agree that the Privacy Notice of Westfield Plastic Surgery has been made available to me.

B. **Authorization to Treat**. I authorize and direct the medical practitioners of Westfield Plastic Surgery and his/her designee to provide medical services and diagnostic services for me as they deem necessary and appropriate. I understand that I have the right to receive information, to request treatment, and to seek a second opinion. Patients 18 years and younger must be accompanied by guardian.

C. **Assignment of Insurance Benefits.** I hereby assign all medical insurance benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans to Westfield Plastic Surgery. I understand that I am financially responsible for co-payments, co-insurance, deductibles, and any other balance not paid for by my insurance plan.

The undersigned patient or patient's guardian hereby acknowledges to have read, understood and agreed to conditions set forth in the Notice of Privacy Practices, Authorization to Treat, Assignment of Insurance Benefits, and, if applicable, Medicare Patient's Information.

____ ____________________
Signature of Patient or Legal Guardian Date

____ ____________________
Printed name of Patient

ETHNICITY (____Black or African American) (____Hispanic) (____White) (____American Indian or Alaskan Native) (____Asian) (____Other)

Your PHARMACY____________________________ **LOCATION**____________________________________

HOW DID YOU HEAR ABOUT US ?? (___ Doctor If Doctor Referral (Name)________________________________)

(___Family) (___Friend) (___Radio) (___Magazine) (__ Patient) (___Insurance Co. Representative Provider List)

(**Online**- ___Google ___Westfieldpsc.com ___Real Self ___Build My Bod ___Other) (___ Other_____________________)

PERSONAL HISTORY

Clinic Name	For Internal Use Only
Westfield Plastic Surgery Center	Medical Record #

Full Name	Preferred Name/Nickname	Birth Date	Today's Date

Personal Medical History (Check if you presently have or have had any of the following)

- ☐ Headache
- ☐ High blood pressure
- ☐ Stroke
- ☐ Phlebitis (blood clots)
- ☐ Heart attack
- ☐ Congestive heart failure
- ☐ Chest pain
- ☐ Heart palpitations (irregular heart beat)
- ☐ Heart murmur
- ☐ High cholesterol
- ☐ Chronic cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Diabetes
- ☐ Anemia
- ☐ Allergies/hay fever/ chronic sinusitis
- ☐ Cancer
- ☐ Ulcer
- ☐ Chronic diarrhea
- ☐ Constipation
- ☐ Nervous stomach
- ☐ Hepatitis
- ☐ Gallbladder disease
- ☐ Low back pain
- ☐ Arthritis
- ☐ Gout
- ☐ Thyroid disease
- ☐ Dizziness/fainting
- ☐ Seizures/convulsions
- ☐ Alcoholism
- ☐ Depression
- ☐ Nervousness/anxiety
- ☐ Psychiatric disorder
- ☐ Osteoporosis
- ☐ Menstrual disorder
- ☐ Incontinence
- ☐ Prostate disease
- ☐ Sexually transmitted disease
- ☐ Frequent infections
- ☐ Rheumatic fever
- ☐ Tuberculosis
- ☐ Chronic rashes
- ☐ Glaucoma
- ☐ Other – Describe:
- ☐ Other – Describe:

Current Medications: (Include vitamins/ supplements) (continued on back)

Drug Allergies (continued on back)

Environmental Allergies (such as latex, pollen, foods) (continued on back)

Do you have a living will? ☐ **Yes** ☐ **No**

WOMEN ONLY:

Pregnant ☐ Yes ☐ No

Planning Pregnancy ☐ Yes ☐ No

Using Birth Control ☐ Yes ☐ No

Method: ______________________

Number of Pregnancies/Births /

Hospitalizations and Major Surgeries (continued on back)

Reason	Year/Age	Reason	Year/Age

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Other	Describe
Heart Disease	☐	☐	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	☐	☐	
High Cholesterol	☐	☐	☐	☐	☐	☐	
Migraine Headache	☐	☐	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	☐	☐	
Mental Illness	☐	☐	☐	☐	☐	☐	
Kidney Disease	☐	☐	☐	☐	☐	☐	
Bleeding Disorder	☐	☐	☐	☐	☐	☐	
Osteoporosis	☐	☐	☐	☐	☐	☐	
Epilepsy/ Seizures	☐	☐	☐	☐	☐	☐	
Other: Describe:	☐	☐	☐	☐	☐	☐	
Other: Describe:	☐	☐	☐	☐	☐	☐	
Other: Describe:	☐	☐	☐	☐	☐	☐	

Habits

	How much/How Long			Describe
☐ Tobacco		☐ Caffeine		☐ Sleep problems
☐ Alcohol		☐ Street drugs		

Please list year of last:

Chest X-ray	Mammogram	EKG
Pap smear	Tetanus shot	Cholesterol

Current Medications: (Include vitamins/ Supplements)	

Drug Allergies

Environmental Allergies (such as latex, pollen, foods)

Hospitalizations and Major Surgeries			
Reason	Year/Age	Reason	Year/Age