

ROSS I.S. ZBAR, MD
-PLASTIC AND RECONSTRUCTIVE SURGERY-

REGISTRATION SHEET

Full Name _____ Today's Date _____
Date of Birth _____ Age _____ Social Security # _____

Home Address _____ City _____
State _____ Zip Code _____
Home Telephone (____) _____ Email _____
Cellular Telephone (____) _____

Marital Status _____ Sex: Male Female

Occupation _____ Name of Employer _____
Employer's Address _____ City _____
State _____ Zip Code _____ Business Telephone (____) _____

Name of Another Contact _____ Telephone _____
Address _____ City _____
State _____ Zip Code _____ Relationship to Contact _____

***** Payment is due at the time of service *****

INSURANCE INFORMATION

Primary Insurance _____ Insurance ID# _____ Group # _____

Secondary Insurance _____ Insurance ID# _____ Group # _____

Subscriber's Name _____ Birthdate _____
Subscriber's Social Security Number _____

Medicare Number (if applicable) _____

Advance Directive (Living Will)? YES NO

Referred by _____
Other Physicians you see _____ Specialty _____
_____ Specialty _____
Pharmacy Name _____ Telephone _____

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RELEASE OF MEDICAL INFORMATION AND PAYMENT

I hereby authorize and direct payment to Ross I.S. Zbar, MD for the medical benefits, if any, otherwise payable to me under terms of my insurance.

I hereby authorize any physician, hospital, or medical facility to provide all information on my medical history to Ross I.S. Zbar, MD that is required for appropriate treatment. I understand that confidentiality will be maintained.

I hereby authorize Ross I.S. Zbar, MD to release Protected Health Information (PHI) acquired in the course of my examination or treatment that is required for appropriate healthcare operations. I also authorize Ross I.S. Zbar, MD to release my Protected Health Information (PHI) to health insurers or contact agents needed to determine benefits payable from my health insurance company / HMO.

I hereby authorize photocopies of this form to be valid as the originals

Signature _____ Date _____

—
Print Name _____

MEDICARE PATIENTS

Beneficiary Lifetime Authorization

“I request that payment of authorized Medicare benefits be made either to me or on my behalf to Ross I. S. Zbar, MD for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.”

Signature _____ Date _____

Print Name _____

CO-PAYMENT STATEMENT

I understand that when I see Ross I.S. Zbar, MD, I am personally responsible for all charges for services rendered. I agree to pay any and all charges that exceed or are not covered in accordance with the cost sharing agreement of my insurance plan. I also understand that payment is due at the time of service. A photocopy of this agreement is as valid as the original.

Signature _____ Date _____

Print Name _____

PRIVACY STATEMENT

At any time, you may request to review the Privacy Notification of Ross I.S. Zbar, MD

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PERSONAL MEDICAL HISTORY

Full Name _____ Date _____

Reason for Visit Today _____

<u>Medication</u>	<u>Dosage</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies _____

Past Surgeries _____ Date _____

_____ Date _____

Other hospitalizations? _____

Do You Smoke? _____ If yes, how many packs per day? _____

Do you have any of the following medical issues?

Ankle swelling	Yes	No
Prolonged Bleeding	Yes	No
Thyroid Problems	Yes	No
Lung Problems	Yes	No
Shortness of Breath	Yes	No
Problems with Scars	Yes	No
Rheumatic Fever	Yes	No
Cancer	Yes	No
High Blood Pressure	Yes	No
Diabetes	Yes	No
Hepatitis	Yes	No
Heart Problems	Yes	No
Eye Problems	Yes	No
Dry Eyes	Yes	No
Kidney Problems	Yes	No

WOMEN ONLY

Are You Pregnant? Yes No

Date of last mammogram _____