Patient Demographics

Name: _____ _____ Today's Date: _____
Last First

Age: _____ Sex: _____ Height: _____ Weight: _____

Primary Care Physician: _____ Phone #: _____

PCP Address: _____

Social History

Do you consume alcohol? ☐ Yes ☐ No If yes , how many per week? _____
Do you smoke? ☐ Yes ☐ No ☐ Occasionally If yes, how many per day? _____ For how many years? _____
* **You must quit smoking two weeks prior to any surgical procedure***

Do you diet? ☐ Yes ☐ No ☐ Occasionally Explain Diet: _____

Do you exercise? ☐ Yes ☐ No ☐ Occasionally What type of exercise: _____

Allergies, Medications and Supplements

Do you have any drug allergies? ☐ Yes ☐ No If yes, please list below:

Medication/Substance	Reaction

Please list all the medications and supplements/herbals you are currently taking below:
Please attach list for more than 5 medications

- Do you take any blood thinners? ☐ Yes ☐ No If yes, ☐ Coumadin ☐ Aspirin ☐ Other: _____

Name of Medication	Dose and Frequency	Reason for taking

Medical History

Cardiovascular System (HEART)
- ☐ High Blood Pressure
- ☐ Heart Attack /Heart Failure
- ☐ Angina (Chest pain)
- ☐ Arrhythmia (abnormal heartbeat)
- ☐ Heart Failure
- ☐ Blood clots (DVT or PE)
- ☐ Bleeding disorder
- ☐ Heart valve problems

If so when? _____

Respiratory System (Lungs)
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Shortness of breath
- ☐ Pulmonary Embolus

If so, when? _____

Gastrointestinal
- ☐ Peptic Ulcer Disease
- ☐ Hiatal / Umbilical Hernia
- ☐ Pancreatitis
- ☐ Gallbladder disease
- ☐ Inflammatory bowel disease
- ☐ Colonic problems

If so, when? _____

➢ Continues on next page

Medical History Continued

Which of the following have you been diagnosed with? (Check all that apply):

Infectious Disease ☐ AIDS ☐ Hepatitis ☐ Herpes If so, when? _____ What type? _____	**Genitourinary** ☐ Urinary Tract Infections ☐ Prostate problem If so, when? _____	**Neurology** ☐ Bellspalsy ☐ Seizures ☐ Stokes/Mini strokes If so, when? _____
Skin ☐ Cold sores ☐ Shingles ☐ MRSA/Staph Infection If so, when? _____	**Cancer** ☐ Uterine ☐ Prostate ☐ Breast ☐ Skin If so, when? _____	**Endocrine** ☐ Diabetes/High blood sugar ☐ Thyroid problems If so, when? _____
Other Medical Conditions _____ _____ _____	**Other Medical Conditions** _____ _____ _____	**Other Medical Conditions** _____ _____ _____

Surgical / Procedure History

Please list past surgeries/procedures:

Surgery/Procedure:	Date:	Reason for surgery:

Acknowledgement

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN:

_____ DATE: _____

Patient Registration

Name: _____ Date: _____
Last MI First

Address: _____ City: _____

State: _____ Zip: _____ Age: _____ Date of Birth: _____

Cell Phone #: _____ May we leave detailed messages on your phone? ☐ Yes ☐ No

Home Phone #: _____

Email address: _____ Social Security #: _____

Occupation: _____ Employer: _____

Ethnicity: Caucasian / African American / Hispanic / Asian / Other: _____

Marital Status: S / M / W Name of significant other: _____

Pharmacy Name: _____ Phone #: _____

Name of emergency contact: _____

Relationship to you: _____ Phone #: _____

May we contact you through email? ☐ Yes ☐ No May we text you? ☐ Yes ☐ No

May we send mail to your home? ☐ Yes ☐ No If no, where would you like mail sent?

_____

Would you like to receive emails on specials or updates? ☐ Yes ☐ No

Please tell us how you heard about us: _____

What would you like to discuss with the Doctor today? _____

_____

_____

_____

Our Clinical Aesthetician and ARNP offer non-surgical procedures; is there anything else we can help you with today?

_____

I HEREBY STATE ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT

_____ _____
PATIENT'S SIGNATURE DATE

Employee Initials: _____

HIPPA & Patient Rights

Patient Consent for the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examination, test results, diagnosis, treatment, and any plans for future care. In addition, it may become necessary to disclose health information to other healthcare providers, laboratories, insurance companies and/or other individuals or agents as permitted or required by state or federal law.

Notice of Patient Acknowledgment of Receipt of HIPAA and Privacy Practice

The Health Insurance Portability & Accountability Act (HIPAA) protects individual's identifiable health information and gives patients' rights with respect to that information. Privacy Practice describes the personal information (including obtaining photographs for medical records) we collect, and how and when we use or disclose "Protected Health Information" (PHI).

Each time you visit our office, a record of your visit is made. This information serves as:

- A basis for planning your care and treatment;
- A means of communication between medical professionals who contribute to your care;
- A legal document describing care you have received;
- A source of information for applying your diagnosis and treatment information to your bill, for payment purposes, so the third-party payer can verify that services billed were provided;
- A tool in educating health care professionals;
- A source of data for medical research;
- A source for planning and marketing with your authorization.

Please note: This practice is committed to training and using (PHI) about you responsibly. As a responsible practice, we are required to:

- Maintain the privacy of your health information;
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

Although your health record is the physical property of this practice, you have certain rights you need to be aware of:

- The right to read "Patient Health Information Privacy Protection Act" & "Patient Bill of Rights and Responsibilities" prior to signing this consent;
- The right to request a copy of "Patient Health Information Privacy Protection Act"
- The right to request restrictions as to how your health information may be used or disclosed to carry out treatment, payment, or healthcare operations

Information about my treatment/care at The Center of Dr. Joshua Halpern may be released to the following individuals:

Name & Relationship: _____ Phone #: _____

Name & Relationship: _____ Phone #: _____

Name & Relationship: _____ Phone #: _____

Patient Consent

By signing this form, you are acknowledging that you understand the "Health Insurance Portability & Accountability Act" (HIPPA) & Privacy Practices providing a more complete description of health information uses and disclosures, and that you have read Patient's Bill of Rights and Responsibilities and are fully aware of your patient rights.

I UNDERSTAND, ACKNOWLEDGE AND ACCEPT THIS CONSENT

PRINT NAME _____ SIGNATURE _____ DATE _____

***Our office does NOT file any insurance claims. ***

Our office does not accept insurance as a form of payment for services provided. Payment for services is to be paid directly to Joshua A. Halpern M.D., P.A.

I AGREE TO BE FULLY RESPONSIBLE FOR ALL PAYMENTS

PRINT NAME _____ SIGNATURE _____ DATE _____

FOR OFFICE USE ONLY

Consent form reviewed by _____ _____
EMPLOYEE SIGNATURE DATE

Patient refused to sign consent _____
REASON FOR REFUSAL