MILFORD MEDICAL & AESTHETIC CARE

Today's Date: _____/_____/_____ Acct. #_____ (Internal Use)

PATIENT REGISTRATION

Name _____
Last First Middle Initial

Address _____
Street City State Zip Code

Home Phone _____ Cell Phone _____

Date of Birth _____/_____/_____ SS# _____-_____-_____ Sex ___Male ___Female

Marital Status ___ Single ___ Married ___ Other:_____ Email _____

Primary Care Physician _____ Referring Physician _____

Employer _____ Occupation _____ Work # _____

Address _____
Street City State Zip Code

How were you referred to our office? _____

PRIMARY HEALTH INSURANCE

Policy Holder Name _____ Policy Holder D.O.B. _____/_____/_____

Relationship to Patient _____ Employer _____

Company Name _____ Policy Number _____ Group Number _____

SECONDARY HEALTH INSURANCE

Policy Holder Name _____ Policy Holder D.O.B. _____/_____/_____

Relationship to Patient _____ Employer _____

Company Name _____ Policy Number _____ Group Number _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship to Patient _____

Address _____
Street City State Zip Code

Home Phone _____ Day Phone _____

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner.

Signature _____ **Date** _____/_____/_____

MMAC Milford Medical And Aesthetic Care ___Dr. Fischer ___Jennifer Fischer PAC

Patient: _____DOB_____ Today's Date_____HT_____WT_____
Your Age: _____Home Phone: _____Work Phone: _____

Medications: (circle if new medicine within the last month)

Latex Allergy: yes_____no_____ **Are you a smoker: yes_____no_____**

Allergies (medications or environmental):

ROS) Have you recently had any of the following: (please check if yes)

___Weight loss	___Nausea/vomiting	___bone pain	___fatigue
___Muscle weakness	___loss of appetite	___fever	___arthritis
___Raymaud's	___shortness of breath	___headache	___swollen glands
___Cough	___depression	___easy bruising	___abdominal pain
___Chest pain	___anxiety	___eye problems	
___Irregular heart beat	___chronic nasal congestion		

Past Medical History: check if positive history

___Blistering sunburns in youth	___Diabetes	___Eczema	___HIV AIDS
___Basal cell Carcinoma	___Thyroid Disease	___Asthma	___Tuberculosis
___Squamous Cell Carcinoma	___Heart Disease	___Hayfever	___Psoriasis
___Actinic Keratosis	___Melanoma	___Stroke	___Osteoporosis
___High Blood Pressure	___Pacemaker	___Seizures	___Hepatitis
___Atypical moles	___Migraines	___Blood Disorders	___Other
___Kidney problems	___Liver disease	___Stomach ulcers	

___Cancer (type_____)

Are you allergic or have you had a reaction to Anesthesia: ___yes ___no
Have you had abnormal bleeding associated with previous surgery or trauma: ___yes ___no
Have you required a blood transfusion: ___yes ___no

Surgical History: (include approximate date)

Family History: If positive identify if Mom, Dad, siblings, children, Aunt, Uncle, or grandparents

Basal Cell Carcinoma_____ Eczema_____
Squamous Cell Carcinoma_____ Psoriasis_____
Melanoma_____ Atypical Moles_____
Breast Cancer_____

Social History: Occupation_____ **Hobbies:**_____
Primary Care Physician_____ Referring Physician:_____
Pharmacy name and Phone #_____
Patient Signature_____
Reviewed by Physician_____Date_____

MILFORD MEDICAL & AESTHETIC CARE

Plastic Surgery Dermatology

PLEASE PROVIDE COPY OF VALID INSURANCE CARD AND A CURRENT PHOTO ID.

I authorize the release of medical information necessary to process the claims for medical benefits, I authorize and assign any payment of medical benefits to Milford Medical and Aesthetic Care, its successors and assigned, or any individual it may designate for serviced provided.

I further agree to pay all costs of collection including reasonable attorney's fees, associated with collection of any amount due to services rendered and performed, I understand that I am financially responsible to to Milford Medical and Aesthetic Care its, successors and assigns and any individual it may designate for any balance not covered by insurance. The assigned will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered a valid original. I hereby authorize said assigned to release all information to secure payment (All rule and regulation of insurance companies than to Milford Medical and Aesthetic Care participates will apply.)

Signature_____ Date_____

Medical Authorization

I request that payment of authorized benefits be made either to me or on my behalf to to Milford Medical and Aesthetic Care for services furnished to me by the provider. I authorize any holder of medical information about me to provide to the Health Care Financing Authority and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature_____ Date_____

Summary of Notice of Privacy Practices

The following is a brief summary of your rights and our responsibilities. A copy of detailed Notice of Privacy Practices (the "Notice") is available for your review. This Summary is for your convenience and is not a substitute for reading the entire Notice and does not modify the terms of the Notice.

1. **Uses and Disclosures of Your Health Information:** We may use the information we develop and collect for treatment by our practice or disclose the information to others to whom we refer you for treatment, for payment for these services and for certain health care "operations" such as improving the competence and quality of our staff and business planning and management. We may disclose your information to our business associates such as medical transcription service, billing services and others who assist in the operations of our practice. We may call you to remind you of appointments and may leave a message on your answering machine if you have one. We may also disclose information to your family about your location, general condition or death. If you are available and able, we will ask your consent first. We may also use your information to recommend products or services related to your care but will not use or disclose your medical information for marketing purposes without your written authorization. Your medical information may be disclosed without your authorization as required by law, for public health purposes, healthcare oversight, including audits and investigations, judicial and administrative proceedings, subject to the limits imposed by state and federal law, and certain other purposes.
2. **Other Uses and Disclosures**: Except as described in the Notice, we will not use or disclose your medical information without your written authorization. You can revoke an authorization at any time, except to the extent that we have already taken action in reliance on the authorization.
3. **Your Health Information Rights:** You have a number of rights under state and/or federal law which are subject to the terms and conditions specified in the Notice:
    a. You may request restrictions on certain uses and disclosures of your information
    b. You may request that you receive your information from us in a certain way
    c. You may inspect and copy your medical records
    d. You may request an amendment to any record you believe is inaccurate
    e. You may request an accounting of disclosures made of your records
4. **Changes to the Notice:** We reserve the right to change the Notice. If we do so, we will post it in our office and provide a copy upon request.
5. **Complaints:** You may file a complaint to our Privacy Official Linda Riso and with the federal government as detailed in the Notice. You will not be penalized for filing any complaint.
6. A copy if this policy has been made available to me.

Signature: _____ **Date:** _____

20 Commerce Park • Milford CT 06460
Ph: (203) 301-5860 Fax: (203) 301-5861 www.drpaulfischer.com