AVIVA
PREMINGER MD
AESTHETIC PLASTIC SURGERY

New Patient Registration Form

Please print clearly and DO NOT abbreviate:

Name: _____
(Last) (First)

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Phone: Home: _____ Business: _____ Cell: _____

Date of Birth: _____ Social Security #: _____ - _____ - _____

Email Address: _____

Insurance: _____ Secondary Insurance: _____

Name of Insurance Policy Holder: _____ Relationship to Policy Holder: _____

Policy Insurance ID #: _____ Group #: _____

Name of Emergency Contact Person: _____

Relationship & Telephone Number: _____

Referred by: Friend/Family: _____ or by □ Print Ad □ Internet □ Other: _____
(Name of referral)

Primary Care Physician: _____

Address & Phone: _____

If patient is a MINOR:

Parent's Name: _____

Phone: _____

REMINDER TO ALL PATIENTS: Dr. Beth Aviva Preminger **DOES NOT** participate with any insurance companies. Payment of charges incurred is due at the time of service and you will be provided with an insurance form that you can submit to your private insurance. Health insurance varies and all services may not be covered. We cannot be responsible for negotiating payments from you insurance company, and while terms such as customary, reasonable and prevailing me be used to limit coverage, full payment of our charge(s) remain your obligation.

Patient/Guardian's Signature: _____

Date Signed: _____

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B. Aviva Preminger, MD

Authorization for Use and Disclosure of Protected Health Information

This form provides authorization to **B. Aviva Preminger, MD** ("the Practice") to use or disclose certain of your personal health information for the purpose(s) described below. It is intended to properly inform you of how this information will be used or disclosed. You should carefully read the information on this form before signing it.

I, _____,(date of birth: _____) authorize the Practice to (choose one): disclose to / obtain from:

With an address at: 969 Park Avenue #1E, New York, NY 10028

The following information:

_____

_____

The disclosure of any part of the medical record deemed to be "psychotherapy notes" will require a separate authorization. I understand that if my records contain information about alcohol and drug abuse, mental health treatment and/or HIV/AIDS status, I authorize the Practice to release such information as part of my medical record only if I place my initials on the appropriate line as set forth below.

Included in information to be released:

____ Alcohol/Drug Treatment

____ Mental Health Information

____ HIV Related Information

Purpose of Information to be Disclosed [If you have requested the use or disclosure of the information but do not, or elect not to, provide a statement of the purpose, the purpose shall be stated as "at the request of the individual"]**:**_____

_____

_____

This authorization shall expire upon the earlier of (i) ____ days from the date of this request or (ii) the following date _____ or (iii) the occurrence of the following:

_____.

I understand that I have the right to revoke this authorization at any time, in writing, by mailing such written notification to the Practice's Privacy Officer, at **B. Aviva Preminger, MD, 969 Park Avenue #1E, New York, NY 10028**.

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Authorization for Use and Disclosure of Protected Health Information (cont.)

I understand that a revocation is not effective to the extent that the Practice has taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer with the right to contest a claim under the policy or to contest the policy itself.

I understand that the Practice will not condition my treatment on whether I provide authorization for the requested use or disclosure if to do so would be prohibited by federal or state law. If a reason exists under law for conditioning my treatment on obtaining this authorization, I have been advised of that fact and of the consequences of me refusing to sign this authorization.

I understand there is the potential for information used or disclosed pursuant to this authorization to be subject to re-disclosure by the recipient if the recipient is not required by law to protect the privacy of the information. I understand that I will receive a copy of this authorization if signed by me.

I hereby authorize the use or disclosure of my health information as described in this form.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Name of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority

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Patient History Form

Please print clearly and DO NOT abbreviate:

Reason for Visit: _____

Height: _____ Weight: _____ Age: _____

Do you exercise regularly? _____ How Often: _____

Is your weight stable? _____

Women only: Bra Size: _____

Medical Conditions and Hospitalizations (date):

_____

_____

_____

_____

_____

Prior Surgical Procedures:

_____ Date: _____

_____ Date: _____

_____ Date: _____

Any problems with surgery or anesthesia? _____

Medications (prescribed, over-the counter, vitamins, and homeopathic:

Medication	Dosage	Frequency

Allergies: _____ Type of Reaction: _____

Family History: _____

_____

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Have you ever smoked? Y N

When did you quit? _____

Do you currently smoke? Y N

If Yes Packs per day: _____ Years: _____

Do you drink alcohol? How much? _____

Do you have diabetes? Y N

Do you have high blood pressure? Y N

Do you have difficulty walking? Y N

Do you sleep propped up in bed? Y N

Do you ankles swell? Y N

Have you ever had a heart attack? Y N

Do you have chest pain? Y N

Do you have a problem breathing? Y N

Have you had asthma? Y N

Do you have any nausea or vomiting? Y N

Do you have abdominal pain?? Y N

Do you have ulcers? Y N

Have you had hepatitis? Y N

Do you have constipation? Y N

Do you use over the counter laxatives? Y N

Do you have arthritis? Y N

Have you ever had a stroke? Y N

Have you ever had a blood clot in your legs? Y N

Do you have any bleeding disorders? Y N

Do you have trouble with you back? Y N

Do you have Lupus or Scleroderma? Y N

Have you been treated with steroids? Y N

Do you get up at night to urinate? Y N

Do you have trouble urinating? Y N

Do you have burning when you urinate? Y N

Have you ever been told you have kidney problems? Y N

Do you live alone? Y N

Women Only:

Is there a possibility that you are pregnant? Y N

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

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Authorized Credit Card Payment Form

I authorize Dr. Aviva Preminger to keep my signature on file and to charge my credit card for:

☐ Remaining portion due prior to surgery.

I authorize Dr. Aviva Preminger to provide:

☐ Credit card information to surgery center for processing operating room fee.
☐ Credit card information to surgery center for processing anesthesia fee.

I understand that this form is valid for one year unless I cancel the authorization through written notice to Dr. Aviva Preminger. I also understand that I will be notified when charges are going to be put onto this card. I also understand that a receipt will be sent in the mail to me for each transaction processed by Dr. Aviva Preminger.

Patient Name

Cardholder Name

Cardholder Address

City State Zip Code

Credit Card Account Number Expiration Date

Cardholder Signature Date

969 Park Avenue, New York, New York 10028• P (212) 706-1900•F (917) 382-4126•www.premingermd.com

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Marketing

As part of our continued efforts to keep our patients informed, we would like to be able to contact you in the future regarding any updates, promotions, and/or any new services we may offer. We are dedicated to respecting your confidentiality in this regard; your information is solely for our in-house use and will not be solicited to any other party.

May we contact you?

□ Yes □ No, thank you.

How we may reach you?

□ Home Phone: _____

□ Work Phone: _____

□ Cell Phone: _____

□ Email: _____

Please note, you can also get more information on our website at www.premingermd.com or stay updated by finding us on Facebook at www.Facebook.com/PremingerPlasticSurgery.