The Princeton Center for Plastic Surgery
THOMAS A. LEACH, M.D.

Registration Form

Today's Date:	Referring Physician:
Primary Physician:	Phone #:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:
Marital Status: □ S □ M □ W □ D Sex: □ M □ F	E-Mail Address:	
Social Security #:	Birth Date:	Age: / Ht: / Wt:
Race:	Ethnicity: □ Hispanic or Latin □ Non-Hispanic □ Prefer not to answer	
Preferred Language: □ English □ Indian □ Spanish □ Chinese □ Russian □ Other		
Street Address:	Home Phone #:	Cell Phone #:
P.O. Box:	City: / State:	Zip Code:
Occupation:	Employer:	Employer Phone #:

INSURANCE INFORMATION

Responsible for Bill:	Birth Date:	Home Phone #:
Address (if different):		
Is this person a patient here? □ Yes □ No	Occupation:	
Employer:	Employer Address:	Employer Phone #:
Primary Insurance:	Subscriber's Name:	
Subscriber's SS#:	Birth Date:	Policy#:
Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Other		Co-Pay:
Secondary insurance:	Subscriber's Name: / Birth Date:	Social Security #:
Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Other		Policy #:
Worker's Compensation Case? □ yes □ no	Motor Vehicle? □ yes □ no	Injury at School? □ yes □ no
Date of Injury:	Place of Injury:	How did it occur?
Insurance Name and Address:		Phone #:
Claims Adjuster's Name:	Claim #:	Policy #:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home Phone #:

CHIEF COMPLAINT/REASON FOR VISIT

Please describe:

First Name:_____ Last Name: _____

DOB:_____ Date:_____

Medical History

PAST MEDICAL HISTORY (check all that apply)	Details
ASTHMA	
BLEEDING DISORDER	
BREAST CANCER	
CHEST PAIN/TIGHTNESS	
DIABETES	
ECZEMA	
HEART DISEASE	
HEART MURMUR	
HEPATITS	
HIGH BLOOD PRESSURE	
HIVES	
KIDNEY STONES	
SKIN CANCER	
SKIN DISEASE	
STROKE	
THYROID DISORDER	
TUBERCULOSIS	
ULCERS	
URINARY TRACT INFECTIONS	
XRAY THERAPY	
OTHER	

ALLERGIES (Drugs, latex, food and adhesive)

MEDICATIONS (Including OTC medication, vitamin and supplements. Please attach list if necessary)

Name:	Dosage:
Name:	Dosage:
Name:	Dosage:
Name:	Dosage:
Name:	Dosage:

PHARMACY

Name:	
Address:	Phone #:

PAST SURGICAL HISTORY

Surgery:	Date:
Surgery:	Date:
Surgery:	Date:
Surgery:	Date:

SOCIAL HISTORY

Smoking: □ Yes □ No Packs/Day: Years: Former Smoker: □ Yes □ No How many years? When did you quit?

Alcohol Intake: □ Yes □ No □ Daily □ Weekly □ Occasionally Caffeine Intake: □ Yes □ No Cups/Day:

First Name:_____ Last Name: _____

DOB:_____ Date:_____

Authorizations

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 controls how the Protected Health Information (PHI) of our patients can be discussed and with whom. This authorizes Dr. Leach and staff of the Princeton Center for Plastic Surgery to discuss your PHI with those you have listed below and in what specific manner.

Individuals to whom your health information may be disclosed (please check all that applies):

Spouse Name:	Phone Number:
Parent Name:	Phone Number:
Child Name:	Phone Number:
Other Name:	Phone Number:

Can we leave messages on your answering machine? □ At Home: □ At Work: □ Cell Phone:

What kind of information can be disclosed? □ All at Doctors discretion □ Tests Ordered/Test Results □ Diagnosis

□ Treatment □ Only a return call □ Medical History □ Surgery/Scheduling Information □ Billing Information

This authorization will remain in effect unless otherwise revoked by the patient in writing. Release of the Protected Health Information covered by this authorization will be disclosed solely for the purpose of keeping designated members informed of your healthcare condition.

I have read and understand the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I, the undersigned, in accordance to HIPAA guidelines, authorize the release of any medical information/photographs about my treatment to other doctors, nurses, technicians or any other personnel involved in my care. I also authorize release of any medical information/photographs in order to bill and collect from my insurance company or third party payer.

Patient Name:	Patient Signature:	Date:

EXPLANATION OF INSURANCE AND FINANCIAL POLICY

Insurance policies, other than preferred provider organizations, are contracts between you, the subscriber, and the insurance company. The doctor can neither alter the contract nor guarantee your payments by the insurance company. We participate with many insurance companies and if your plan requires a referral it is your responsibility to obtain the referral from your primary care physician. We cannot render any services without the appropriate referral.

We do not render services on the assumption that your charges will be paid by your insurance company, and patients who carry medical or surgical insurance should know that he or she is ultimately responsible for payment of all services rendered.

I, the undersigned, hereby authorize payment of medical and surgical benefits directly to Thomas A. Leach, M.D. and/or The Princeton Center for Plastic Surgery. I understand that all medical and surgical charges incurred by me (or my dependent) are my financial responsibility whether or not paid by insurance. I also understand that I am responsible for paying in advance for all co-pays, deductibles and co-insurance amounts prior to receiving any surgical services.

ASSIGNMENT OF BENEFITS

Patient/Legal Guardian Name:	Signature:

CONSENT FOR PHOTOGRAPHY

Consent for Photography: It is a routine part of any plastic surgery practice to take preoperative, intraoperative, and postoperative photographs. I consent to the use of these photographs for scientific meetings, scientific publications and showing other prospective patients.

Patient/Legal Guardian Name:	Signature:	Date:

Returned Checks: A fee of $30.00 will be charged on any checks returned by the bank for insufficient funds.

Cancellations/No Show Fee: There will be a $75 charge for all appointments not cancelled within 24 hours prior.