

Health Information as of _____ (enter today's date)
 (Please Print Legibly & Fill In or Correct All Fields)

Patient:		Email address:		
Address:	Apt. #	City	State	Zip Code
Phone:	Cell:	SSN:	DOB:	
What surgery are you considering? Breast Body Nose Face Eyes Botox Laser Other: _____			Height:	Weight:
Referred by: T.V. Radio Google Internet Friend: _____ Other: _____				
Have you ever been involved in any medical litigation?			Occupation:	
Emergency Contact:		Phone:	Relationship:	

DO YOU NOW OR HAVE YOU EVER HAD..... (You must circle an answer for each individual item)

Heart Trouble	Yes	No	Glaucoma or Eye Problems	Yes	No
Heart Attack	Yes	No	Visual Disturbances	Yes	No
Heart Pain	Yes	No	Error in Refraction	Yes	No
Palpitation or Irregular Pulse	Yes	No	Other Eye Problems	Yes	No
Extra Heart Beats	Yes	No	Hepatitis	Yes	No
Stroke	Yes	No	Yellow Jaundice	Yes	No
Hypertension	Yes	No	Gallstones or Gallbladder Trouble	Yes	No
Blood Pressure Abnormalities	Yes	No	Cirrhosis of the Liver	Yes	No
Abnormal EKG	Yes	No	Alcoholism or Drug Dependency	Yes	No
Rheumatic Fever	Yes	No	Esophageal Varices	Yes	No
Dropsy or Heart Failure	Yes	No	Frequent Indigestion	Yes	No
Digitalis Treatment	Yes	No	Ulcers	Yes	No
Shortness of Breath	Yes	No	Gastritis	Yes	No
Chest Pain	Yes	No	Colitis	Yes	No
Asthma	Yes	No	Problem Constipation	Yes	No
Bronchitis	Yes	No	Vomiting Blood	Yes	No
Pneumonia	Yes	No	Tarry or Bloody Bowel Movements	Yes	No
Tuberculosis	Yes	No	Hemorrhoids	Yes	No
Smokers Cough	Yes	No	Goiter or Thyroid Disorders	Yes	No
Emphysema	Yes	No	Diabetes	Yes	No
Coughing or Spitting of Blood	Yes	No	Skin Disorders	Yes	No
Hay Fever	Yes	No	Arthritis	Yes	No
Major Allergies	Yes	No	Fracture of Neck or Spine	Yes	No
Palsy or Paralysis	Yes	No	Bleeding Tendency or Disorder	Yes	No
Nervous Breakdown	Yes	No	Abnormal Bleeding after Tooth Extraction	Yes	No
Nervous Disorder	Yes	No	Airway Obstruction (Nasal)	Yes	No
Insomnia	Yes	No	Breast Cysts, Tumors, Abscesses	Yes	No
Drug Habit	Yes	No	Nipple Discharge (Apart from Normal Lactation)	Yes	No
Self-Destructive Tendencies	Yes	No	Kidney Disorder	Yes	No
Psychiatric Hospitalization or Care	Yes	No	Blood Transfusion	Yes	No
Thyroid Problems	Yes	No	Seizures or convulsions or fainting spells	Yes	No
Kidney or Renal Disease	Yes	No	Black outs	Yes	No
Heart murmur	Yes	No	Dentures, bridges, capped teeth or crowns	Yes	No
Piercing other than the ears	Yes	No	Loose teeth	Yes	No
Positive blood test for: HIV, AIDS, Hepatitis	Yes	No	Cosmetic bonding to teeth	Yes	No
Missed or irregular last menstrual period	Yes	No	Any family members with bleeding problems	Yes	No
Family history of cancer, heart trouble, stroke	Yes	No	Any family members with anesthesia problems	Yes	No

1. **Please list all present medications**, including birth control pills, hormones, and vitamins, herbal medication, diuretics, weight loss drugs. **Include over-the-counter medications.**

2. Do you have an allergic reaction to any medication? Yes No Which?

3. Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used for anesthesia?
 Yes No If yes, when and where? _____
4. Have you ever been on cortisone or steroid treatment? Yes No When? _____
5. Do you smoke? Yes No If so, how much? _____ For how long? _____
6. Are you pregnant? Yes No When was you last normal menstrual period? _____
7. When was your last physical exam? _____ By whom? _____
8. Have you ever been under psychiatric care? Yes No When? _____ Why? _____
9. Have you had any recent blood work done? Yes No Where? _____
10. Is there anything else you think the doctor should know? _____

11. Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons: (include where, when and why for each surgery)
SURGICAL OPERATIONS: _____
HOSPITALIZATIONS: _____
12. Have you been on any other cosmetic surgery consultations? If yes, with whom? _____

Financial Agreement and Insurance Policy

I agree to pay to the order of Michael Salzhauer, M.D., P.A. and/or Bal Harbour Plastic Surgery Associates for services rendered at time of service. I understand that Michael Salzhauer, M.D., P.A. is an out of network provider and that the processing of insurance claims is a service and does not relieve me of my financial obligation. All insurance benefits paid to the patient are to be signed over to Michael Salzhauer, M.D., P.A.. If your insurance company has not paid your account in full within 60 days, you will be responsible for charges. An outstanding balance after insurance benefits applied is the responsibility of the patient and must be paid in full. Designation of Authorized Representative- I hereby designate this medical provider to act as my representative during an insurance or plan benefits appeal in the event of a coverage denial. I understand that this medical provider or practice has the right to decline or accept this designation at the time a denial is received. If this medical provider or practice accepts this designation, the outcome of any appeal is not guaranteed and I agree to pay all charges which remain unpaid by the insurance carrier or welfare benefit plan regardless of the outcome of any appeal. I authorize any holder of medical information about me to release to my insurance companies and their agents any information needed to determine these benefits payable for related services.

I understand the financial policy of Michael Salzhauer, M.D., P.A. and/or Bal Harbour Plastic Surgery Associates that I am financially responsible for all bills incurred. I have been informed and understand the refund policy of Michael Salzhauer, M.D., P.A. and/or Bal Harbour Plastic Surgery Associates in that all deposits are nonrefundable and that refunds are not given for any service or treatment.

By signing below, I agree that the above information is complete and accurate to the best of my knowledge.

Would you like for us to find out if you are approved for financing and interest free payments? Yes No

Signature: _____ Date: _____

Consent for Purposes of Treatment, Payment and Healthcare Operations (HIPAA)

I consent to the use or disclosure of my protected health information by Bal Harbour Plastic Surgery Associates for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Bal Harbour Plastic Surgery Associates. I understand that diagnosis or treatment of me by Dr. Michael Salzhauer may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Bal Harbour Plastic Surgery Associates is not required to agree to the restrictions that I may request. However, if Bal Harbour Plastic Surgery Associates agrees to a restriction that I request, the restriction is binding on Bal Harbour Plastic Surgery Associates / Dr. Michael Salzhauer.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Michael Salzhauer and Bal Harbour Plastic Surgery Associates has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I hereby grant permission for the use of any of my medical records, illustrations photographs, or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

I understand I have a right to review Bal Harbour Plastic Surgery Associates's Notice of Privacy Practices prior to signing this document. The Bal Harbour Plastic Surgery Associates's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Bal Harbour Plastic Surgery Associates. The Notice of Privacy Practices for Bal Harbour Plastic Surgery Associates is also provided at the offices located at 1140 Kane Concourse, Bay Harbor Islands, Florida and on the practice website at www.BalHarbourSurgery.com . This Notice of Privacy Practices also describes my rights and the Bal Harbour Plastic Surgery Associates's duties with respect to my protected health information.

Bal Harbour Plastic Surgery Associates reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Bal Harbour Plastic Surgery Associates's website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Description of Personal Representative's