WESTON PLASTIC SURGERY, INC.
ROBERT E. ROTHFIELD, M.D., F.A.C.S.
2300 N. Commerce Parkway, Suite 202
Weston, FL 33326

COSMETIC PLASTIC SURGERY
DIPLOMATE-AMERICAN BOARD
OF PLASTIC & RECONSTRUCTIVE SURGERY

PATIENT REGISTRATION FORM

Please Print

PATIENT NAME: _____ Today's Date: ____/____/____
Last First M.I.

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Address: _____
Street Apt # City State Zip

Date of Birth: _____/_____/_____ Age: _____ SS #: _____-_____-_____ Marital Status: **S M D W** (circle one)

Name/Address of Employer: _____

Spouse/Relative's Name: _____ Phone Number: ( ) _____

Spouse/Relative's SS #: _____/_____/_____ Spouse/Relative Employer: _____

HOW WERE YOU REFERRED TO OUR OFFICE: _____

E-MAIL ADDRESS: _____

INSURANCE INFORMATION:

Name of Insurance Company: _____ Name of Policy Holder: _____

Member ID #: _____ Group/Plan #: _____

If you also have a Secondary Insurance Company please give name: _____

Is this a work-related injury? If so, Name of Employer: _____

Date of Injury: _____/_____/_____ Will you be represented by an attorney: □ **YES** □ **NO**

Is your visit related to an automobile accident? □ **YES** □ **NO** If YES, Date of Accident: _____/_____/_____

YOUR FINANCIAL RESPONSIBILITY:

I hereby request that my insurance carrier make payment directly to Robert E. Rothfield, M.D., F.A.C.S., for any and all services rendered by this facility.

I, the undersigned, understand that Robert E. Rothfield, M.D., F.A.C.S., will bill my insurance carrier for services rendered upon verification of coverage by my insurance company. I also understand that should my insurance company fail to render payment for these services, I am fully responsible for all charges incurred, and will pay in full for all services. **I understand that I am responsible for the payment of any and all deductibles, co-insurance, and/or co-pay amounts. I understand that I am responsible for any balance due after the payment by my insurance company.** Should it become necessary for Robert E. Rothfield, M.D. F.A.C.S., to engage in professional collection efforts, I will be held responsible for any and all additional costs of collection including but not limited to agency fees, attorney fees, court costs and interest.

I further understand that if my injury is in litigation against a third party, this in no way relieves me of my obligation to pay for the services rendered. I understand that payment of the fees is not contingent upon settlement of litigation. However, I hereby instruct my attorney to pay Robert E. Rothfield, M.D., F.A.C.S., in full (including all interest or additional charges) directly from the proceeds from any settlement or judgment rendered on my behalf.

PATIENT'S SIGNATURE: _____ **DATE:** _____/_____/_____
(IF A MINOR, PARENT OR GUARDIAN'S SIGNATURE ONLY)

PATIENT HISTORY FORM

Problem(s) for which you are seeking plastic surgery: _____

_____

General Health: Good _____ Fair _____ Poor _____. If not good, please explain: _____

_____

Height: _____ Weight: _____ Name, Address and Telephone Number of Internist/Medical Doctor: _____

_____

List all **MEDICAL CONDITIONS & ALL CORRESPONDING MEDICATIONS** you are now taking: _____

_____

_____

List all **PREVIOUS SURGERY AND ANY COMPLICATIONS** or after affects: _____

_____

List all **PAST INJURIES** (please explain): _____

_____

Usual daily consumption: **ALCOHOL: _____ TOBACCO: _____**
List **ALL ALLERGIES TO MEDICATION:** _____

	Yes	**No**
Do you have asthma or hay fever?	_____	_____
Have you ever had a bad reaction to a local anesthesia (Novocain, etc.)?	_____	_____
Do you have High Blood Pressure?	_____	_____
Do you have Heart Disease?	_____	_____
Have you ever had Scarlet Fever or Rheumatic Fever? If so, when? _____	_____	_____
Do you usually bleed easily (cuts, surgery, tooth extractions)?	_____	_____
Do you usually bruise easily?	_____	_____
Do you form keloids or large scars?	_____	_____
Do you have any active skin disease (hives, eczema or rash)?	_____	_____
Do you have frequent infections or boils?	_____	_____
Have you taken steroid medications or cortisone by mouth? If so, when? _____	_____	_____
Have you ever had psychiatric care? If so, when? _____	_____	_____
Have you ever had ANY facial treatments or surgery? If so, when? _____	_____	_____

Have you ever had any significant illness of the following? (circle if YES)

Ears Nose Throat Chest Stomach or Intestines Eyes Lungs
Heart Kidney Nervous System

If circled, please explain: _____

_____

Please make sure that you have answered ALL of these questions honestly and to the best of your ability.

PATIENT SIGNATURE:_____ DATE: _____/_____/_____