Sabrina A. Lahiri, MD PA
Plastic and Reconstructive Surgery
119 Vision Park ◇ Shenandoah, TX 77384
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Patient Registration Form

DATE _____

Patient:

Patient's Name:_____
(Legal) Last Name First Middle Name

Address:_____

City_____ State_____ Zip:_____

Home Phone (____)_____Cell Phone(____)_____Work Number (____)_____

It is okay to leave messages at my (please circle all that apply) Home Cell Work email

Date of Birth: _____/____/_____ Age: _____ Texas Driver's License#_____

SS Number: _____ Male_____ Female_____

Email Address:_____

Employer:_____ Occupation:_____

Reason for Visit:_____

Primary Care Physician:_____ Phone: _____

Pharmacy Name and Phone Number: _____

How did you hear about Lahiri Plastic Surgery?_____

Emergency Contact:

Emergency Contact Name (person that does not live in your household):

Name: _____ Relationship to Patient: _____

Phone Number (_____)_____

Patient Medical Health History

Name: _____ Date: _____

Height: _____ Weight: _____ Marital Status: S M D W

Describe your current health status. Excellent_____ Good_____ Fair_____ Poor_____

Allergies List ANY reactions you have had to medications including over the counter drugs; describe the Reaction. □ Check here if none

_____

Any known allergies to your skin? (i.e. Adhesive tape, latex, lotions, etc.)

_____

Medications List ALL prescription, over-the-counter, Vitamins, Supplements, herbal/tea medications you are currently taking.

□ Check here if none

Medication	Dosage	Medication	Dosage
_____	_____	_____	_____
_____	_____	_____	_____

Please check if you have or have taken any of the following: □ Check here if none

___Tenormin	___Herbals/Teas	___Nembutal	___Other "beta blockers"
___Librium	___Female Hormones	___Phentermine	___Other "calcium channel blockers"
___Tranquilizers	___Birth Control	___Inderal	___Other fish oil supplements
___Anti-Depressants	___Diuretics	___Verapamil	___Marine Omega-3 fatty acids
___Steroids			

Past Surgical History List ALL previous surgeries including date(s). □ Check here if none

_____

_____

Past Medical History List ANY medical conditions for which you are being treated. □ Check here if none

_____

Social History

Tobacco: Yes No _____ packs per day _____years

Vaping: Yes No Drugs: Yes No

Exercise: None Daily Weekly

Alcohol: ___Beer_____ # of glasses per week _____# of years

___Wine_____ # of glasses per week _____# of years

___Spirits____ # of glasses per week _____# of years

Family History Has any member of your family (parents, grandparents, siblings, aunts, uncles, cousins, etc) had any of the following medical problems? If yes, please indicate who.

Breast Cancer: Yes/No Relationship (maternal/paternal) _____ Living/Deceased

Skin Cancer: Yes/No Relationship (maternal/paternal) _____ Living/Deceased

Patient Medical Health History- Continued

Please mark any symptoms or conditions have experienced or are currently experiencing.

□ **Check here if none**	o Nose Bleeds	o Varicose Veins
General:	o Sinus Trouble	o Reynaud's Phenomenon
o Weight Gain	***Neck:***	***Back:***
o Weight Loss	o Swollen Glands	o Back Aches/Stiffness
o Fatigue	o Enlarged Thyroid	o Back Injury
o Depression	***Endocrine:***	***Digestive:***
o Nervousness	o Hypothyroidism	o Trouble Swallowing
o Trouble Sleeping	o Diabetes	o Heartburn/Ulcer
o Anxiety	o Insulin Pump	o Frequent Nausea/ Vomiting
Head:	***Liver:***	o Frequent Diarrhea
o Migraine Headaches	o "Yellow" Jaundice	o Frequent Constipation
o Tension Headaches	o Hepatitis	o Irritable Bowel
o Head Injury	***Heart:***	o Crohn's Disease
Eyes:	o High Blood Pressure	***Urinary:***
o Decreased Vision	o Heart Trouble/Disease	o Difficulty Urinating
o Wear Glasses/Contacts	o Heart Attack	o Kidney Stones
o Pain	o Rheumatic Fever	o Kidney Disease
o Double Vision	o Heart Murmur	***Neurological:***
o Dry Eyes	o Chest Pain/Angina	o Stroke
o Glaucoma	o Palpitations	o Seizure Disorder
o Cataracts	o Irregular Heart Beat	o Memory Loss
o Frequent Irritation	o Matrial Valve Prolapse	o Fainting
o Frequent Itching	***Lungs:***	o Paralysis
Ears:	o Trouble Breathing	***Bleeding:***
o Decreased Hearing	o Asthma	o Easy Bruising
o Pain	o Emphysema	o Excess Bleeding Post Op
o Drainage	o Pneumonia	o Anemia
o Noise/Tinnitus	o Tuberculoses	o Blood Transfusion
o Balance Trouble/Vertigo	o Shortness of Breath	o Bleeding/Clotting Issues
Nose & Throat:	***Arms/Legs:***	***Breasts:***
o Frequent Sore Throat	o Pulmonary Embolism	o Lump or Mass
o Hoarseness	o Arthritis	o Nipple Discharge
o Nasal Stuffiness	o Rheumatoid Arthritis	***Autoimmune:***
o Nasal Allergies	o Phlebitis	o Lupus

For Females Only:

Are you pregnant? _____ Number of children_____ Bra size_____

Number of pregnancies_____ Did you breast feed? _____

Number of C-Sections_____ Breast lump/mass or discharge? _____

Number of live births_____ Date of last mammogram_____

I attest that this medical health history is true, accurate, and complete. Further, I understand that ANY omissions, falsifications, or otherwise incorrect information that I provide, regardless of the reason, may directly affect my medical care and increase my risks of complications. I agree to accept full and complete responsibility to inform the office of any changes in my medical history that occur while I am under the care of Dr. Lahiri.

Patient Signature_____ Date_____

Financial Policy

Payment:

I understand that full payment is expected at the time of service. We accept cash, check, Visa, MasterCard or American Express.

Insurance:

We may accept assignment of insurance benefits. Insurance claims are filed as a courtesy to our patients. The insured is required to provide proof of coverage and is responsible for paying any remaining deductible, co-insurance, and non-covered charges. *Your insurance policy is a contract between you and your insurance company. We are not a party to that contract, therefore, it is the responsibility of the insured to see that our claim is paid. If your insurance company has not paid your account in full within 45 days, the balance will automatically be transferred to you as the guarantor.* Any changes in insurance status should be promptly reported to the office staff. Please be aware that some, and perhaps all of the services provided may be non-covered services and not be considered reasonable and necessary under the Medicare Program and/or other medical insurance companies. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph.

**If your insurance company denies payment of services provided by Dr. Sabrina Lahiri for "not being medically necessary", you will be informed of this and will be responsible for the charges.*

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients

Adult Patients are responsible for full payment at time of service.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment.

Surgery

Deductible, co-insurance and co-payments are due prior to surgery date, unless other arrangements have been made.

Patient Signature_____ Date_____

INSURANCE ONLY BELOW:

*Please sign both the authorization and the assignment and present card to the receptionist:*_____

Insurance Authorization

I hereby authorize Sabrina A. Lahiri, MD to furnish all necessary information including photographs to process my claim(s) for service(s) rendered from this date forward and concerning my illness and treatment to all of my insurance carriers. Also, I consent to this consultation and treatment and further consent to the release of my medical records upon request.

Patient Signature _____ Date_____

Insurance Assignment

I hereby authorize payment of all medical benefits rendered to myself or my dependants to Sabrina A. Lahiri, MD and understand that I am responsible for all remaining balances not covered by my insurance carrier. A copy of this signed authorization can be accepted as an original.

Patient Signature _____ Date_____

Information needed for verifying coverage and benefits

Name of Insured: _____ Date of Birth _____

Authorization to Release Information About Patient's Condition/Treatment

In accordance with the Medical Privacy Act of Texas, Physicians and/or staff are unable to release any information pertaining to your condition, treatment and/or care without your consent. If you authorize us to release and/or obtain information regarding your care other than yourself, please complete the following authorization.

I hereby authorize Dr. Sabrina A. Lahiri, MD, and/or staff to release information pertaining to my condition and/or care to only those family members and/or others involved with my care as listed below:

_____

Name Relationship

_____

Name Relationship

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

I authorize the release all medical information, including diagnosis that may be necessary for referrals to other physicians, medical facilities, medical equipment companies, and any other services deemed necessary by Dr. Lahiri.

Patient Signature_____ Date_____

Consent for Release of Photographs

I authorize Dr. Sabrina A. Lahiri and such assistants, and photographers as they may engage for this purpose, to take photographs of me as they may desire before, during and after the operation and to permit such photographs to be published in professional journals/books. This is for the purpose which they may deem fit in the interest of medical education, knowledge, or research.

I understand that I will not be entitled to monetary payment of any other consideration as a result of any use of these images and/or my interview.

Patient Signature_____ Date_____

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Patient Signature_____ Date_____

CONFIDENTIAL CONSENT

Please print the telephone number(s) where you want to receive calls about your appointments, labs, pathology and x-rays results, or other health care information if other than your home number:

( ) _____

I am fully aware that a cell phone is not a secure and private line.

Can confidential messages (i.e., appointments reminders, etc.) be left on your home answering machine, voice mail or email? (Please circle one) Yes or No

If email is acceptable please provide email where you wish to receive confidential messages.

_____

I am fully aware my health information can be transmitted by electronic transmission, by fax transmittal, by internet or email.

PATIENT NAME_____ (guardian if under 18 years)

PATIENT/GUARDIAN SIGNATURE_____ **DATE** _____

Lahiri
PLASTIC SURGERY

January 1, 2014

REGARDING: INSURANCE OFFICE VISITS

As of January 1, 2014, Lahiri Plastic Surgery will no longer file claims with your insurance company for office visits, only.

You will be responsible for the office visit at time of service.

1. **A receipt will be provided for you to send to your insurance company for direct reimbursement to you.**

2. **You will receive an EOB (explanation of benefits) with reimbursement (if due). If any discrepancy, please contact our office.**

Signature: _____ **Date:** _____