



Sabrina A. Lahiri, MD PA
Plastic and Reconstructive Surgery
119 Vision Park ♦ Shenandoah, TX 77384
Phone: 281-419-1123 ♦ Fax: 936-273-8737

Patient Registration Form

DATE _____

Patient:

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

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 numbers.

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

Email Address: _____ Male _____ Female _____

Employer: _____ Occupation: _____

Reason for Visit: _____

Primary Care Physician: _____ Phone: _____

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, and 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	___ Verapami	___ 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

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.

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

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 _____

Social Security # _____ - _____ - _____ ID# _____ Group # _____

Relationship to Patient (please circle) self child spouse

**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 _____

Insurance Information for Patients

Name of Patient _____

Date _____

Primary Insurance

Name of Insured: _____ Date of Birth _____

Social Security # _____ - _____ - _____ Group # _____

Employer: _____

Employer's address: _____

Relationship to Patient (please circle) self child spouse

Name of Insurance Company: _____

Address: _____ Telephone# _____

Secondary Insurance

Name of Insured: _____ Date of Birth _____

Social Security # _____ - _____ - _____ Group # _____

Employer: _____

Employer's address: _____

Relationship to Patient (please circle) self child spouse

Name of Insurance Company: _____

Address: _____ Telephone# _____

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 _____



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: _____