

PATIENT REGISTRATION FORM

Last Name:

First Name:

Home Address:

City:

State:

Zip:

Mailing Address:

City:

State:

Zip:

Home Phone:

Cell Phone:

Work Phone:

Other:

Email address:

Social Security #:

Birthdate:

Age:

Employer:

Occupation:

Marital Status: M S D W

Family member contact:

Phone:

What procedure are you interested in? _____

Were you personally referred by someone? _____

If not, how did you hear about Dr. Lowenstein?

(circle all that apply)

Word of mouth

Google

SBplasticsurgeon.com

LocateaDoc

Yellowpages.com

Citysearch

Breastimplants411

Yahoo

LoveYourLook

other: _____

INSURANCE INFORMATION

Insured's name:

Insurance Company:

Insured's SS#:

Policy #:

Group #:

Insurance Co Mailing address:

I authorize the release of any medical information necessary to process this claim and I authorize payment of surgical and medical benefits to Dr. Lowenstein when applicable. I accept responsibility for fees for medical services rendered which are determined by insurance not to be covered.

Signature _____

Date: _____

Health Questionnaire

PATIENT NAME: _____

When was your last **physical examination**? ____/____/____

How is your **general health**? _____

Who is your **primary physician**? _____

What **medical conditions** are you presently being treated for?

Please list your **previous surgeries and any complications including anesthesia reactions:**

Surgery	Date	Complications

Please list any reasons for **hospital admissions:**

Do any illnesses run in your **family medical history**? (include anesthesia and bleeding problems)

Has any of your relatives had **breast cancer**? YES / no
if so, who? _____

When was your last **mammogram**?
____/____/____

Please list all **medications to which you have allergies or intolerances:**

Medication Allergy	Reaction

Please list all **medications you are currently taking:**

What is your **height**? _____ What is your **weight**? _____

Health Questionnaire

PATIENT NAME: _____

Please circle the appropriate answer

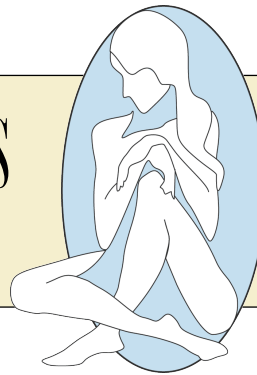
EYE	yes	no	HEART/LUNGS	yes	no
Visual Loss	Y	N	Heart attack	Y	N
Dry eyes	Y	N	Congenital heart disease	Y	N
Itchy or irritated eyes	Y	N	Heart murmur	Y	N
Blurred or double vision	Y	N	Palpitations / irregular heart beat	Y	N
Crossed or lazy eyes	Y	N	High blood pressure	Y	N
Cornea problems	Y	N	Stroke	Y	N
Thyroid eye disease	Y	N	Shortness of breath	Y	N
Wear glasses or contacts	Y	N	Chronic lung disease	Y	N
Previous eyelid surgery	Y	N	Cough	Y	N
NOSE			Asthma	Y	N
Difficulty breathing through nose	Y	N	BREAST		
Previous nose injury	Y	N	Breast pain or discomfort	Y	N
Nasal Allergies	Y	N	Breast cysts or lumps	Y	N
Nose bleeds	Y	N	Previous breast biopsies	Y	N
Sinus conditions	Y	N	Breast cancer	Y	N
Previous nose or sinus surgery	Y	N	OTHER		
FACE			Liver disease(hepatitis, cirrhosis)	Y	N
Radiation to face or neck	Y	N	Kidney or bladder problems	Y	N
Facial paralysis or weakness	Y	N	Bleeding disorders	Y	N
Acne or facial skin problems	Y	N	Easy bleeding or bruising	Y	N
Previous facial surgery	Y	N	History of blood clots	Y	N
PSYCHIATRIC			Blood transfusions	Y	N
Any recent crisis in your life?	Y	N	Autoimmune disease	Y	N
Have you ever:			Unusual scarring	Y	N
been treated for depression?	Y	N	Thyroid disease	Y	N
been treated for anxiety?	Y	N	Stomach or digestive disease	Y	N
received psychiatric treatment?	Y	N	Spine or back problems	Y	N
been hospitalized for psychiatric treatment?	Y	N	Diabetes	Y	N
LIFESTYLE			LIFESTYLE		
Do you drink alcohol?	Y	N	DO YOU SMOKE?	Y	N
If yes how much per week:	_____		HAVE YOU EVER SMOKED?	Y	N
Do you take recreational drugs?	Y	N	MIGHT YOU BE PREGNANT?	Y	N
If yes what kinds:					

Signature: _____

Date: _____

ADAM LOWENSTEIN, MD, FACS

Montecito Plastic Surgery



1110 Coast Village Circle
Santa Barbara, CA 93108

T 805-969-9004

F 805-969-7224

adamlowenstein@mac.com

www.sbplasticsurgeon.com

Photo Consent

In connection with the plastic surgical services which I am receiving, I consent that photographs may be taken of me or parts of my body, under the following conditions:

1. These photographs may be taken only with the consent of Dr. Lowenstein under conditions approved by him.
2. The photographs shall be used for medical records. If, in the judgment of Dr. Lowenstein, medical research, education, or science will be benefited by their use, such photographs and information relating to my case may be published and republished in medical journals or books or used for any other purpose in the interest of medical education, knowledge or research. It is specifically understood that I will not be identified by name.
3. I understand that these photographs may be shown on a confidential basis to other patients in the practice who are considering the same type of surgery.

Financial Agreement

1. **RELEASE OF INFORMATION:** Montecito Plastic Surgery may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Dr. Adam D. Lowenstein for reimbursement for services rendered, and (2) any health care provider for continued patient care. Montecito Plastic Surgery may also disclosed on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal Law, statute or regulation. A copy of this authorization may be used in place of the original.
2. **OTHER INSURANCE:** The undersigned agrees that I am individually obligated to pay in full two weeks prior to all services rendered to me by Dr. Adam D. Lowenstein if I belong to a plan that does not contract with Montecito Plastic Surgery. I understand proper documents will be provided following the procedure so I can submit the claim to my insurance, or I have the option to utilize billing services with an additional 8% charge due two weeks prior to services.
3. **NON-COVERED SERVICES:** I understand Montecito Plastic Surgery contracts with Medicare and Sansum Health Clinic only relate to services "covered" by these health service plans. Accordingly, the undersigned accepts full financial responsibility due two weeks prior to all items or services rendered, which are determined by the health service plan not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Montecito Plastic Surgery to obtain necessary health care service plan authorizations.

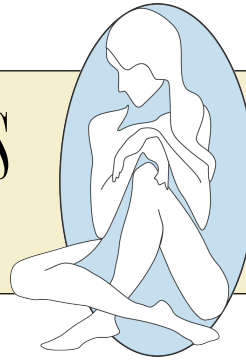
Signature _____

Date _____

Witness _____

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HIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION, PLEASE REVIEW CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI, which is information about you, including demographics, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Your PHI may be used or disclosed by your physician, our office staff and others outside of our office that we involved in your care and treatment for the purpose of providing health care services to you, paying your health care bills, supporting the operation of our practice, and any other use as required by law.

Treatment: We will use and disclose your PHI to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party such as a physician to whom you have been referred, an anesthesia provider, or a home health care agency.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example obtaining approval for a hospital stay may require that your relevant PHI be disclosed to your health plan.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of our practice, such as quality assessment, employee review, physician training, licensing, and conducting or arranging for other business activities. For example, we may call you by name in the waiting room. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI, without your authorization, in the following situations: As Required By Law, Health Oversight, Research, Public Health Issues, Communicable Diseases, Abuse or Neglect, RDA Requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Criminal Activity, Military Duty, National Security, Workers' Compensation, inmates and any other required uses and disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with section 164.500. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object, unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to inspect and copy your PHI. However, under federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled in anticipation of or use in a civil, criminal, or administrative action or proceeding; and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, it will not be restricted. You then have the right to use another physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us.

You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you a copy. You have the right to receive an accounting of certain disclosures we have made of your PHI.

We reserve the right to change the terms of this notice and will inform you by mail of the changes. You then have the right to object or withdraw as provided in this notice. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint by notifying our Privacy Officer. We will not retaliate against you for filing a complaint. We are required by law to maintain the privacy of PHI and provide individuals with this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this notice, please ask to speak with our Privacy Officer. This notice became effective on April 14, 2003.

Your signature acknowledges that you read the Notice of Privacy Practices and consent to the above.

Signature: _____ Date: _____