## THE PLASTIC SURGERY GROUP OF ROCHESTER, LLC

Name:_____ Sex:_____ Marital Status:_____
Date:_____
Address:_____ Date of Birth:_____Age:_____
_____ Home Phone:_____
_____ Work Phone:_____
E-mail Address:_____

Social Security #:_____ Employer:_____

Occupation:_____ Work Address:_____

Spouse:_____ Spouse Work Phone:_____

Family physician:_____ **Physician who sent you:**_____

Would you like to be added to our email mailing list? _____

Primary Insurance:_____ Secondary Insurance:_____
Address:_____ Address:_____
Subscriber #:_____ Subscriber #:_____
Subscriber Name:_____
Subscriber date of birth:_____ Subscriber date of birth:_____
Subscriber employer:_____ Subscriber employer:_____

If patient is a minor:
Father:_____ Work Phone:_____
Mother:_____ Work Phone:_____

### EMERGENCY ROOM VISIT

Were you treated in the Emergency Room for this condition:_____ When:_____
Which Hospital?:_____

### WORKMAN'S COMPENSATION INJURY

Is this a work-related injury?_____Date of injury?_____
Employer at the time of injury?_____Case number:_____
Workman's comp carrier and address:_____

### MOTOR VEHICLE ACCIDENT

Does this visit relate to a motor vehicle accident?_____Date of accident_____
Responsible insurance company and address:_____
Policy holder:_____Policy Number:_____

**THE PLASTIC SURGERY GROUP OF ROCHESTER**

## PATIENT AGREEMENT

I certify that the information provided on the patient history form is true and accurate, and that there have been no omissions from my medical history.

I consent to the taking of clinical photographs in the course of diagnostic and surgical procedures for use of treatment, education, and or research purposes.

I authorize the release of any medical or other information necessary to process insurance claims and authorize payment of benefits to the treating physician for services provided.

I agree to be financially responsible for all services rendered by the treating physician. A payment on account, or an insurance co-payment is due at the time services are rendered. I will be financially responsible for all charges not covered by my insurance. I will pay all financial obligations in a timely fashion; special financial arrangements can be made in certain circumstances. I accept that delinquent accounts may incur finance, collection, and or legal charges.

_____

Name (print), if under 18 parent or guardian must sign.

_____

## Signature

_____

**ACKNOWLEDGEMENT OF RECEIPT OF**

# NOTICE OF PRIVACY PRACTICES

I, _____, hereby acknowledge that I received a copy of The Plastic Surgery Group of Rochester, LLC (Rochester Hand Center) Notice of Privacy Practices. (See Forms Section on Website)

_____ _____

Date **Signature of Patient or Patient's Representative**

_____

Description of Representative's Authority

# THE PLASTIC SURGERY GROUP of ROCHESTER, LLC

**Specialists in Plastic and Hand Surgery**
**www.rochesterplasticsurgery.com**

Timothy P. O'Connor, MD, FACS
Ralph P. Pennino, MD, FACS
Mark S. Davenport, MD

Jeffrey A. Fink, MD
Ines M. Carrasquillo, MD, FACS
Julie Sylvester, RPA-C

## Permission Regarding Communications

Please check the following as you wish and sign at the bottom of the page:

Leave information regarding appointments:

| | |
|---|---|
| answering machine | ____ |
| office voice mail | ____ |
| w/ another person | ____ |
| send through mail | ____ |
| send via e-mail | ____ |
| cell phone | ____ |

E-mail address:_____

Leave other medical info on:

| | |
|---|---|
| answering machine | ____ |
| office voice mail | ____ |
| w/ another person | ____ |
| send through mail | ____ |
| send via e-mail | ____ |
| cell phone | ____ |

As a patient, you may choose whether to allow us to communicate information about your health status with the persons you list below. If you do not wish information about your health care to be shared with another individual, you do not have to complete this section.

I, _____, give permission to the Plastic Surgery Group of
(please print your name here)
Rochester to discuss information regarding my health with the following individuals:

Name of individual: _____

Telephone number: _____

Relationship to patient: _____

Name of individual: _____

Telephone number: _____

Relationship to patient: _____

_____ _____
Patient's signature Date