

Patient Intake Questionnaire

Name: _____

Date: ___/___/___

How were you referred to the office? (Please circle one)

Google Search Friend _____ Physician _____

Have you visited Dr. Westreich's website, www.newfaceny.com? YES NO
If so, did you find the information helpful? YES NO

Have you seen Dr. Westreich's comments on www.realself.com? YES NO
If so, did you find the information helpful? YES NO

Family History:

Are there any conditions or diseases related to your visit today that run in your family?

NO YES

Do you have any allergies to medication?

NO YES

Medication History:

Please list all medications currently taking, including herbal or dietary supplements. Please include dose and frequency if known:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Additional Information you would like the doctor to know? _____

Signature of Patient: _____

Date ___/___/___

Please turn over for side 2.

Patient Intake Questionnaire

Name: _____

Date: ___/___/___

Current Medical Survey

Are you currently experiencing any of the following symptoms? Please comment where appropriate.

- | | | | |
|---|-----------|------------|-------|
| • General (Weight change, fatigue, fever) | NO | YES | _____ |
| • Nasal obstruction? (Please indicate side(s)) | NO | YES | _____ |
| • Post nasal drip or “runny nose” (Please indicate color of discharge) | NO | YES | _____ |
| • Headaches or facial pressure symptoms lasting more than a day (please provide location) | NO | YES | _____ |
| • Chest pain, palpitations, abnormal heart beat | NO | YES | _____ |
| • Asthma, cough, or shortness of breath | NO | YES | _____ |
| • Problems with bleeding or bruising | NO | YES | _____ |
| • Reflux, stomach pain, dark colored or bloody stool, trouble swallowing solid or liquid food | NO | YES | _____ |
| • Arthritis, joint swelling, muscle pain | NO | YES | _____ |
| • Skin rash, discoloration, or other lesion | NO | YES | _____ |
| • Isolated muscle weakness, or memory loss | NO | YES | _____ |
| • Double vision, blurry vision, or dry eyes | NO | YES | _____ |
| • Hearing loss, ear discharge, ear infection | NO | YES | _____ |
| • Voice change or loss | NO | YES | _____ |
| • Dental problems | NO | YES | _____ |

Past Medical History

Have you ever been diagnosed with any of the following disorders? Please comment where appropriate.

- | | | | |
|---|-----------|------------|-------|
| • Heart disease | NO | YES | _____ |
| • Hypertension (high blood pressure) | NO | YES | _____ |
| • Emphysema or COPD | NO | YES | _____ |
| • Asthma | NO | YES | _____ |
| • Bleeding disorder | NO | YES | _____ |
| • Diabetes | NO | YES | _____ |
| • Thyroid disease | NO | YES | _____ |
| • Stroke or other neurological disorder | NO | YES | _____ |
| • Psychiatric disorder | NO | YES | _____ |
| • Kidney or bladder disease | NO | YES | _____ |
| • Immune disorder | NO | YES | _____ |
| • Cancer | NO | YES | _____ |

Do you have any concerns for cosmetic appearance? If so, describe below:

Would you like the doctor to tell you about specific cosmetic services that are offered? YES NO



RICHARD W. WESTREICH M.D., FACS

Facial Plastic, Reconstructive & Nasal Surgery
www.newfaceny.com
45 West 67th Street
New York, N.Y. 10023
212-595-1922



FINANCIAL POLICY

Patient Name: _____

Please review our office policy regarding financial responsibility for medical care provided in our office.

Please initial one of the following:

____ 1. **Payment without insurance or out of network care. This includes Cosmetic services**

____ 2. **Patient With insurance. You are responsible for**

- € Copays: Please pay at the time of service. If billing is done later, then a handling fee may be applied
- € Deductables and Coinsurance
- € Care considered “not medically necessary” or “cosmetic” by your insurance company.

Payment of outstanding balances is required before follow up visits are initiated

Due to the prohibitive costs of billing for small balances, we ask that you keep a credit card on file with the office. As with all your personal and medical information, we will not release this information without your permission. We regret the need for this policy and hope that you understand the necessity.

I authorize Richard W. Westreich MD PLLC to charge my credit card for amounts not to exceed \$_____.

Credit Card #: _____ Exp Date: _____ CV2: _____

Cardholder's Name: _____ Signature: _____

Patient responsibility

____ I understand that it is my responsibility to know the terms of my insurance coverage and to monitor compliance with the limits of my plan. I understand that I will be responsible if services exceed the limits of my plan.

I have read and agree to the Financial Policy.

Signature: _____

Name: _____

Date: _____