NEW PATIENT INFORMATION

LAST NAME | FIRST NAME

FEMALE □ MALE □

MARITAL STATUS: □S □M □W □D

SOCIAL SECURITY #

DATE OF BIRTH: / /

EMPLOYER:

HOME ADDRESS:

WORK ADDRESS:

CITY STATE ZIP

CITY STATE ZIP

HOME # ( ) -

CELL # ( ) -

WORK # ( ) -

EMAIL ADDRESS:

EMERGENCY CONTACT

NAME: RELATIONSHIP:

TELL # ( ) -

PHYSICIAN INFORMATION

REFERRING PHYSICIAN:

PRIMARY CARE PHSYICIAN:

SPECIALTY:

NAME

ADDRESS

TEL # ( ) -

NAME

ADDRESS

TEL # ( ) -

OTHER PERTINANT PHYSICIANS:

SPECIALTY:

NAME

ADDRESS

TEL # ( ) -

SPECIALTY:

NAME

ADDRESS

TEL # ( ) -

INSURANCE INFORMATION

PRIMARY

POLICY #

SUBSCRIBER: □ SELF

SECONDARY

POLICY #

□ OTHER

SUBSPECIALIST COPAY: $_____

EFFECTIVE DATE: / /

ADDRESS:

NAME:

RELATIONSHIP:

ADDRESS:

SS# DOB: / /

AUTHORIZATIONS

I hereby assign to Richard Westreich MD any insurance or other third party benefits available for health care services provided to me. I also understand that if benefits are assigned, or if by contractual agreement, payment to the practice will be made by my insurance, that I am responsible for any co-payments and deductibles and that these amounts are due at the time services are rendered. I understand that the practice has the right to refuse or accept assignment of such benefits (except when prohibited by contract). I also understand that, in the event that services rendered are not covered by “insurance,” I will accept financial responsibility for all services provided to me. If benefits are not assigned to this practice, I will forward to the practice all insurance payments that I receive for services rendered to me.

SIGNATURE: DATE:

I authorize the release of any medical or personal information as is necessary to process this claim based upon the “HIPAA notice of Privacy Practices” information provided to me under separate cover. This information is on file as a permanent record and may be amended as is necessary

SIGNATURE: DATE

New Patient Intake Questionnaire (Please Complete Both sides of this form)

Name:_____ Weight/ Height: _____/ _____’ _____”

How were you referred to the office? (Please circle all that apply)

Google Search Friend _____ Physician _____ Other _____

Current Medical Survey

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

• 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, difficulty swallowing solid or liquid food	**NO**	**YES**	
• Arthritis, joint swelling, muscle pain	**NO**	**YES**	
• Skin rash or other skin 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, wax	**NO**	**YES**	
• Voice or Throat Problems	**NO**	**YES**	
• Dental problems	**NO**	**YES**	
• Do you currently use any illegal drugs	**NO**	**YES**	

Past Medical History

Have you ever been diagnosed with any of the following disorders? Please comment when necessary.

• 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** _____
- Sleep Apnea **NO** **YES** _____

Are you a current or past smoker? YES NO If past smoker, quit: _____

For women: Are you pregnant or currently nursing? YES NO

New Patient Intake Questionnaire (Please Complete Both sides of this form)

Name:_____ Date: ____/____/____

Allergies: Do you have any allergies to prescription medication?

NO YES _____

Please provide PHARMACY NAME/PHONE NUMBER/zip code:

So that we can electronically prescribe or call in any medications for you

_____

Medication History:

Please list all medications currently taking, including herbal or dietary supplements.

*We do **not** need information on the dose or frequency:*

_____ _____

_____ _____

_____ _____

_____ _____

Surgical History: Please list any Surgery under General Anesthesia.

If related to current problem, please provide the name of previous surgeon.

Surgery	Year

Surgery	Year

Are there any conditions or diseases related to your visit today that run in your family?
NO YES _____

Have you visited Dr. Westreich's website, www.newfaceny.com? YES NO
Have you seen Dr. Westreich's comments on www.realself.com? YES NO

Is there any additional information you would like the Dr. Westreich or his staff to know?

_____

_____

_____

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

_____

Would you like to learn about specific cosmetic services that are offered such as Botox, Fillers, Laser treatments, Elective Facial Surgery, or Aesthetician treatments (Facials, Peels, Dermabrasion, and skin care products)? YES NO

Signature of Patient:_____ Date____/____/____

RICHARD W. WESTREICH M.D., FACS
Facial Plastic, Reconstructive & Nasal Surgery
www.newfaceny.com
969 Park Avenue, Suite 1C
New York, NY 10028
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:_____

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

Office Cancellation Policy

We are fortunate that the office has a high demand for patient appointments. Our office, as a policy, does not overbook and makes every attempt to create a schedule which will remain, in most instances, on time. On order to ensure that every patient has fair access to schedule timely appointment, we have adopted the following policy towards last minute cancellations and no shows.

Office Visit

We expect our patients to inform us in a timely manner of changes to their schedule. While your personal reasons may vary, the ultimate result of a late cancellation or no show is time that another patient was not given for their personal health needs.

For non-emergent circumstances, **we expect 3 business day notice of cancellation for routine appointments**. If compelling issues are present, please let the office know.
Failure to cancel your appointment in a timely manner will result in the following payment prior to rescheduling:

$50 late cancellation fee
$250 no-show fee

Procedure and Surgery

Procedures are often given a large block of time in order to be performed. Additional per diem staff is sometimes required for your procedure and implants or other materials are required to be purchased in advance. **The office does require a deposit for any surgery or implants ordered on your behalf.** Surgery Deposits are refundable to the patient with 4 weeks notice of any cancellation or date change.

We expect 10 business days notice of cancellation for all in office procedures. If compelling reasons are present, please let the office know. Failure to cancel your procedure appointment in a timely manner will require the following payment prior to re-booking:

$250 late cancellation fee for insurance based procedures
50% late cancellation fee for cosmetic procedures

Thank you in advance for your cooperation in this matter.

Signature_____ Print_____

Date_____