SCOTT J. ZEVON MD, FACS
NEW PATIENT FORM
PLEASE WRITE CLEARLY AND COMPLETE ALL APPLICABLE INFORMATION. COSMETIC PATIENTS CAN SKIP INSURANCE SECTION.

PURPOSE OF CONSULTATION ____

NAME ____

ADDRESS ______________________________________ APT # ______________

CITY, STATE & ZIP ______________________________________ E-MAIL ______________

PHONE: WORK (____)______________ HOME (____)______________ (CELL) (____)______________

PRIVACY INSTRUCTIONS FOR CALLS OR E-MAIL:____

SOC. SEC. # ______________ SEX ______________ DATE OF BIRTH ______________

MARITAL OR OTHER STATUS ______________ OCCUPATION ______________

EMPLOYER NAME & ADDRESS ____

____

NAME OF GUARDIAN (IF PATIENT IS MINOR) ____

HOW DID YOU HEAR OF DR. ZEVON (DOCTOR, PATIENT, FRIEND, MAGAZINE, YELLOW PAGES, WEBSITE, ETC.)?______________

NAME OF WEBSITE(S) VISITED ____

REFERRING DOCTOR ADDRESS & PHONE ____

COMPLETE THE INSURANCE INORMATION IN THE BOX BELOW ONLY IF YOU SEEK INSURANCE COVERAGE. IF YOU HAVE A MANAGED CARE PLAN, YOU ARE RESPONSIBLE FOR OBTAINING A VALID REFERRAL. DO YOU HAVE ONE? ______ INSURANCE DOES NOT USUALLY COVER COSMETIC SURGERY, BUT MAY BE APPLICABLE IF THE SURGERY IS MEDICALLY NECESSARY. ASK US IF YOU THINK YOUR SURGERY MAY BE COVERED, AND IF DR. ZEVON IS A PROVIDER FOR YOUR PLAN. IF APPROPRIATE, DR. ZEVON WIL MAKE EVERY EFFORT TO PROVIDE YOU WITH THE INFORMATION REQUIRED TO SUBMIT AN OUT-OF-NETWORK CLAIM TO YOUR INSURANCE COMPANY. IF YOU SEEK INSURANCE COVERAGE, BRING YOUR INSURANCE CARD WITH YOU. DR. ZEVON MAY ENGAGE AN INDEPENDENT PROFESSIONAL BILLING SERVICE TO ASSIST IN PROCESSING YOUR CLAIM.

NAME OF POLICYHOLDER ______________________ RELATIONSHIP TO PATIENT ______________

PRIMARY INSURANCE CO. ______________________TYPE ______________

ADDRESS ______________________________________ PHONE (____)______________

GROUP # ______________POLICY # ______________SECONDARY INSURANCE CO.______________

TYPE ______________ ADDRESS ______________________________________

PHONE (_____) ______________GROUP # ______________ POLICY # ______________

PAYMENT POLICY: I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES AND THAT PAYMENT IS REQUIRED AT THE TIME OF MY VISIT. IF I HAVE COMPLETED THE INSURANCE BOX, I AGREE TO ASSIGNMENT OF INSURANCE BENEFITS TO SCOTT J. ZEVON MD, PC, AND I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES NOT COVERED BY INSURANCE INCLUDING CO-PAYMENTS, CO-INSURANCE, AND UNCOVERED CHARGES. I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS AN INSURANCE CLAIM.
HIPAA STATEMENT: I HEREBY ACKNOWLEDGE THAT I HAVE BEEN PRESENTED WITH A COPY OF DR. ZEVON’S NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

SIGNATURE (GUARDIAN SIGN FOR MINOR PATIENT): ______________________ DATE: ______________

SCOTT J. ZEVON MD, FACS
MEDICAL HISTORY QUESTIONNAIRE
PLEASE WRITE CLEARLY AND COMPLETE ALL APPLICABLE INFORMATION

NAME____

TODAY'S DATE______________________DATE OF BIRTH____

LIST ALL MEDICATIONS (PRESCRIPTION, NON-PRESCRIPTION, OVER-THE-COUNTER, ASPIRIN, TYLENOL, COLD MEDICATIONS, VITAMINS, SUPPLEMENTS, HERBAL REMEDIES, ETC.) YOU ARE TAKING:____

____

ARE YOU ALLERGIC TO ANY DRUGS OR MEDICATIONS?
- ❑ NO
- ❑ YES. IF YES, WHAT YOU ARE ALLERGIC TO:

____

DO YOU USE DRUGS OTHER THAN PRESCRIPTION OR OVER-THE-COUNTER DRUGS?_________________________________

DO YOU SMOKE?_____________HOW MUCH?___________FOR HOW LONG?___________________________

DO YOU DRINK ALCOHOL?___________HOW OFTEN?____

CLICK THE BOX IF YOU HAVE ANY OF THE FOLLOWING: ASTHMA DIABETES HYPERTENSION
MITRAL VALVE PROLAPSE BLEEDING TENDENCIES OR EASY BRUISING OBESITY
I HAVE NONE OF THE CONDITIONS LISTED IN THIS SECTION

DO YOU HAVE ANY OTHER CURRENT MEDICAL PROBLEMS OR SIGNIFICANT MEDICAL HISTORY:
- ❑ NO
- ❑ YES. IF YES, PLEASE DESCRIBE: ____

____

DO YOU HAVE A FAMILY HISTORY OF CANCER, HEART DISEASE OR STROKE?
- ❑ NO
- ❑ YES. IF YES, PLEASE DESCRIBE: ____

____

HAVE YOU HAD ANY SURGERY, INCLUDING ANY PLASTIC SURGERY?
- ❑ NO
- ❑ YES. IF YES, GIVE DATE & NAME OF PROCEDURE: ____

____

HAVE YOU EVER BEEN UNDER PSYCHIATRIC CARE?_____WHEN AND BY WHOM? ______________________________

DO YOU EXERCISE REGULARLY?_____ HOW OFTEN?_______ ARE YOU ON A SPECIAL DIET? _____ TYPE: ___________

HEIGHT _____ WEIGHT ______ DATE OF LAST PHYSICAL EXAM:____

BY WHOM AND WHERE____

DATE OF LAST: CHEST X-RAY__________EKG_______ EYE EXAM ________________________

FEMALE PATIENTS:ARE YOU PREGNANT? _____HOW MANY PAST PREGNANCIES? ______ HOW MANY CHILDREN? _______ DID YOU BREAST FEED?_____HAVE YOU HAD A MAMMOGRAM? _____ DATE AND LOCATION OF MAMMOGRAM ___ _______________
BRA SIZE (FOR BREAST PATIENTS) __________WAS YOUR LAST PERIOD NORMAL?_____ ARE YOU IN MENOPAUSE?________

SIGNATURE OF PATIENT (OR GUARDIAN IF MINOR)_________________________DATE________

CONSENT TO TAKING AND PUBLICATION OF PHOTOGRAPHS

By my signature below, I hereby consent to before and after surgery photography for the purpose of documenting my plastic surgery in my medical records maintained in the ordinary course of business by Scott J. Zevon M.D., P.C. By checking the appropriate box below, I grant or deny additional limited use(s) of my photographs. For the additional uses, I understand that my name will not be revealed and my photographs will be carefully edited to remove or obliterate personal identification marks. Any photographs used will be cropped to focus on the area of the surgery.

Yes	No	Show my photographs to other patients in Dr. Zevon's office
Yes	No	Post my photographs on Dr. Zevon's website, or web pages in plastic surgery sites displaying Dr. Zevon's photos
Yes	No	Use my photographs to illustrate lectures and presentations to an audience of medical professionals, and to illustrate scientific journal articles or books for medical professionals
Yes	No	Use my photographs to illustrate newspaper and magazine articles featuring Dr. Zevon, or to illustrate presentations or lectures by Dr. Zevon to the general public

All photographs will be taken only with the approval of Dr. Zevon, and under such conditions and at such times as may be approved by Dr. Zevon. Photographs may be taken by Dr. Zevon, or by an employee or photographer selected by him who has signed a confidentiality agreement concerning patient medical records.

____

NAME OF PATIENT (PRINT)

____

SIGNATURE OF PATIENT OR GUARDIAN (IF PATIENT IS UNDER 18)

____

DATE