Restifo Plastic Surgery
PLASTIC & RECONSTRUCTIVE SURGERY
Richard J. Restifo, MD Amanda Roche, PA-C P:203.772.1444 F: 203.907.0503

PATIENT INFORMATION (Please Print)

Date: _____

How did you hear about us?: Referral (name) _____

Patient: _____
Last First M.I.

Responsible Party (if patient is a minor): _____

Relationship to Patient: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Social Security #: _____

Name of your (PCP) physician: _____ Phone: _____

Sex: M F Age: _____ Birthdate: _____ Single Married Divorced/Separated

Email: _____

For monthly specials, and practice information only! We do not sell our email lists to anyone, ever.

Reason for Visit: _____

Business Address: _____

Occupation: _____ Business Phone: _____

Spouse's Name (if applicable): _____

Spouse's Social Security # _____ Employed By: _____

Business Address: _____

Occupation: _____ Business Phone: _____

In Case of Emergency, Contact: _____ Phone: _____

Women Only Number of Pregnancies _____ Number of children _____

Date of last Mammogram _____ Results _____

Did you breast feed? _____ Do you perform regular self examinations on your breasts? _____

_____ _____

(Authorized Signature of Patient or Responsible Party) (Date)

If you have any questions, please call us at (203) 772-1444.
200 South Orange Center Road, Orange, CT 06477

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PATIENT HEALTH HISTORY

Name : _____ Age : _____ HT/WT :_____

Please indicate yes or no to the following questions. Your answers are for our records only and will be considered confidential

1. Have you had any serious illnesses or operations? (including cosmetic surgery) Yes No
   If so, please describe _____
2. Have you been hospitalized or had a serious injury within the past 5 years? Yes No
   If so, please describe _____
3. Have you had abnormal bleeding associated with previous surgery or trauma? Yes No
4. Have you ever required a blood transfusion? Yes No
5. Do you have any allergies? Yes No
6. Are you allergic or have you reacted adversely to any of the following:
   a. Local anesthesia Yes No
   b. Penicillin or other antibiotics Yes No
   c. Sulfa drugs Yes No
   d. Barbiturates, sedatives, or sleeping pills Yes No
   e. Aspirin Yes No
   f. Latex Yes No
   g. Other _____
7. **Please list all present medications**, including birth control pills, hormones, and vitamins, herbal medication, diuretics, weight loss drugs. **Including over-the counter medications.** _____
8. Do you smoke? Yes No If so, how much? _____ For how long? _____

Medical History

Have you ever had any of the following? (Please circle the appropriate response)

Heart Disease	Yes / No	Herpes	Yes / No	Tuberculosis	Yes / No
Lung Disease	Yes / No	Venereal Disease	Yes / No	Heart Attack	Yes / No
Diabetes	Yes / No	Syphlis	Yes / No	Joint Replacement	Yes / No
High Blood Pressure	Yes / No	HIV or Aids	Yes / No	Bleeding Tendency	Yes / No
Asthma	Yes / No	Hepatitis	Yes / No	Skin Cancer	Yes / No
Blood Clots in Legs	Yes / No	Stomach Problems	Yes / No	Arthritis	Yes / No
Rheumatic Fever	Yes / No	Mitral Valve Prolapse	Yes / No	Thyroid Disease	Yes / No
		Glaucoma	Yes / No	Kidney Disease	Yes / No
		Rheumatic Heart Disease	Yes / No	Heart Murmur	Yes / No

Family History

Do you or any of your relatives had any of the following? (Please circle the appropriate answer)

Breast Cancer	Yes / No	Diabetes	Yes / No	Cancer	Yes / No
Melanoma	Yes / No	Kidney Disease	Yes / No	If so, what kind? _____	
Heart Disease	Yes / No	Stroke	Yes / No	Any other? _____	
High Blood Pressure	Yes / No	Depression	Yes / No		
Hemophilia	Yes / No	Anemia	Yes / No		

Review of Symptoms

Have you had any of the below listed symptoms in the past year?

Fever & Chills	Yes / No	Weight Change	Yes / No	Swollen Lymph Nodes	Yes / No
Skin Lesions/Rash	Yes / No	Abdominal Pain	Yes / No	Dentures	Yes / No
Headache	Yes / No	Chronic Cough	Yes / No	Wear Contacts	Yes / No
Dry Eyes	Yes / No	Chest Pain	Yes / No	Easy Bruising	Yes / No
Wheezing	Yes / No	Taken Steroids	Yes / No	Anxiety	Yes / No
Urinary infection	Yes / No	Jaundice	Yes / No	Fainting Spells	Yes / No
Swollen Feet	Yes / No	Breast Lump	Yes / No	Stomach Ulcers	Yes / No

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PRIMARY INSURANCE

Name of individual on membership card _____

Name of insurance carrier _____

Address _____

ID Number _____ Group number _____

Insured Amt of Deductible $ _____ Do you have a cop-pay? _____ Amt $ _____

Insure's lace of employment _____ Phone No. _____

1. Does your HMO/PPO require a referral or a phone call from your primary care physician? Yes / No

2. Name of physician _____ Phone No. _____

SECONDARY INSURANCE

Name of individual on membership card _____

Name of insurance carrier _____

Address _____

ID Number _____ Group No _____

PATIENT DISCLAIMER

To Our Patients . . . This Patient Information Sheet is in compliance with the Health Insurance Portability and Accountability Act of 1998 (HIPPA) and all patient Information obtained is Confidential. In order to comply with the requirements of the HIPAA and certain privacy regulations adopted pursuant to the act (Privacy Rule), the practice has adopted policies and procedures with respect to it use and disclosure of Protected Health Information. We understand that your protected health information is personal, and we are committed to protecting this information. In order to provide you with quality care and to comply with certain legal requirements, we create records of the care and services you receive from us. The Notice of Privacy Practices (NPP) its use and disclosure by our office applies to all these records.

In some cases, our fee for service is not covered by your insurance company even though we participate with them. We want our patients to be aware of the fact that they are responsible for any and all medical services performed and/or rendered by Richard J. Restifo, M.D. including and not limited to any previous "prior authorization" and or pre-certification received by your insurance company which your insurance may not cover or deny.

I understand that I (the patient and/or guarantor) am responsible for any charges incurred by the above named patient and promise to pay promptly the amount of such charges that are not paid by any insurance carrier, including co-payments due at the time of the visit for any such reason. Regardless of any insurance plan provisions regarding deductibles and/or co-insurances will become the responsibility of the patient/ guarantor. I/We accept responsibility to pay the entire bill. In the event that this office needs to obtain legal assistance in the collection of any unpaid balance(s), I/we agree to pay costs and attorney fees, as allowable by law, and may obtain a photocopy of the agreement at the patient request.

If you are not familiar with your insurance carrier coverage, we ask that you discuss your policy with your employer and/or insurance representative BEFORE charges are incurred.
Please note: If the referral is not received, by either the patient or your primary care physician, at the time of your visit, the fee for service becomes you, the patient, responsibility.

_____

Financially Responsible Person's Signature Date

AUTHORIZATION AND PATIENT CONSENT TO RELEASE MEDICAL RECORDS FOR BILLING PURPOSED IS GRANTED BY ME. I consent to the use and disclosure of my Protected Health Information (PHI) by this office for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the health care operations of this Practice. I understand that diagnosis or treatment of my by the practice my be conditioned upon my consent as evidence by my signature on this document.

Signature _____ Date _____

MEDICARE PATIENTS: I request that payment under the Medicare/Metrahealth insurance program be made directly to Richard J. Restifo, M.D. on any bills or service furnished by their physicians during my lifetime. I understand that I may be held responsible for any portion of these bills after Medicare has paid the provider, or for charges Medicare does not cover.

Signature _____ Date _____

I (the patient and/or guarantor) authorize this office to call my home (to leave a message via an answering service device or communicate with a family member), and/or have permission to call my place of employment to confirm any dates, times, appointments, or surgery protocol with their physician, Richard J. Restifo, M.D.

Signature _____ Date _____