SEIFF CENTER
for Aesthetic & Reconstructive Surgery

PLEASE PRINT NEATLY

Primary Care Dr.: _____

Cardiologist: _____

Eye Doctor:_____

Pharmacy: _____ **Preferred Outpatient Lab:** _____

ALLERGIES:

Please list **ALL** allergies:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

SURGICAL HISTORY: Please list **ALL** procedures/surgeries

_____ **I have not had any procedures and/or surgeries**

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Surgical Complications:

Do you have a history of anesthesia complications?

□ None □ Difficult Airway □ Difficult IV Access □ PostOp Nausea/Vomiting

MEDICATIONS

Do you have a written list? *If yes, please give to front desk so a copy can be made.*

[ ] I agree that the **Seiff Center for Aesthetic & Reconstructive Surgery, PA** can access my pharmaceutical records electronically.

LIST OVER THE COUNTER MEDICATIONS BELOW:

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Have you ever been treated for / diagnosed with:

Cardiovascular Disease: N/A_____

□ Cholesterol □ High Blood Pressure □ Coronary Artery Disease

□ MI / Heart Attack - Year(s) _____ □ Chest Pain / Angina □ Cardiac Stents

□ Heart Failure □ Irregular Heartbeat □ Pacemaker / Defibillator

Do you take blood thinners? □ Yes □ No Type: _____

Year of your last EKG? _____ Echo? _____ Stress Test? _____

Location of EKG, Echo & Stress Test: _____

Lung Disease: N/A_____

□ Asthma □ Tuberculosis □ COPD / Emphysema

□ Sleep Apnea CPAP use? □ Yes □ No CPAP Compliant? □ Yes □ No

Tobacco Use? □ Yes □ No Smoked ____ Packs/Day for _____ years. Quit: _____ **Never Smoker _____**

Gastointestinal Disease: N/A_____

□ Hiatal Hernia □ Reflux / Indigestion □ **Hepatitis / Jaundice** □ Cirrhosis of the liver □ **IBS**

Alcohol Use? □ Yes □ No Frequency/Amount _____

Recreational Drug Use? □ Yes □ N

Neuromuscular & Bone Disease: N/A_____

□ Migraines/Headaches □ **Depression** □ Anxiety □ Parkinson's □ Bells Palsy

□ Confusion/Dementia □ Chronic Pain □ Arthritis □ Seizures

□ Rheumatoid Arthritis (Age & Year of Diagnosis _____) Stroke / Mini Stroke □ Yes □ No

Deficits from stroke? _____

Kidney & Endocrine Disease: N/A_____

□ Hypothyroid □ Hyperthyroid □ Difficulty passing urine □ Recent steroids

□ **Kidney** Failure □ **Recent UTI** □ Peritoneal Dialysis Hemodialysis □ Yes □ No (Frequency _____)

□ Insulin Dependent **Diabetes** (Type I) □ Non-Insulin Dependent **Diabetes** (Type II) Daily Blood Sugar Range _____

Miscellaneous: N/A_____

□ Easy Bruising / Bleeding Tendencies □ Reaction to blood tranfusion ____ **HIV/AIDS**

□ **Cancer** (Type: _____) □ Chemotherapy □ Radiation

□ Skin Cancer (Basal Cell, Squamous Cell and/or Melanoma) □ Lupus

Have you had any hospitalizations in the last 6 months? □ Yes □ No When? _____

Which hospital? _____ What were you hospitalized for? _____

Patient Information

SEIFF CENTER
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Patient who purchase cosmetic filler:

The Seiff Center has two office locations. (Dover/Lewes) Your filler will be kept in the office where you purchased and received your treatment. If you choose to schedule in a different location (Dover/Lewes) you are responsible to inform us at the time of scheduling. If you do not and you have your purchased product in the other office (Dover/Lewes) you will need to reschedule or purchase a new syringe. We do not have backup filler at $0 cost.

_____ _____

Patient **Date**

Medical Insurance:

Dr. Seiff accepts some insurance plans. When making your appointment with Dr. Seiff please verify he participates in your specific plan. Since your medical care and cost are ultimately your responsibility, you must understand your insurance plan. Without proper referrals or not following insurance carrier guidelines, you could be responsible for higher co pays and deductibles**. We do not participate with Cigna HealthSprings**.

We will submit insurance claims as a courtesy to you. If your insurance plan requires a referral from your primary care physician, you are responsible to bring it in on with you for your initial appointment.

We will ask to make a copy of your insurance card and photo identification card. If you are an established patient and have any changes in insurance coverage or personal information, please notify us upon your arrival.

Financial Policy:

Ultimately you are responsible for the fees for services provided to you. We accept various methods of payment, including cash, checks, money orders, VISA, MasterCard and debit cards. Payment is due at time of service unless arrangements are made in advance.

If we submit your services to an insurance carrier and they have not paid within 45 days, we will request payment directly from you. You will be responsible for contacting your insurance carrier for payment or resolution of claim processing.

In the event that your account is turned over to a third party for collection purposes, you will be responsible for the account balance and the collection agency fee of 35% of the balance turned over.

Rescheduling/Administrative Fee:

We value your time and our appointments are scheduled with adequate time to accommodate your care and issues. We also do our best to run on schedule and try to avoid any prolonged wait for the patient.

Patients who **consistently** cancel/miss appointments will be charged a fee of $75.

Our office routinely does appointment reminder calls but it is not our responsibly to remind you of your appointment. **You are ultimately responsible for the fee if you miss your appointment.**

_____ _____ _____

Patient/ Guarantor Signature **Witness** **Date**

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PATIENT REGISTRATION FORM:

Patient Information:

First Name:_____M.I.:_____Last Name: _____
Street Address:_____
City:_____State:_____Zip Code:_____
Home Phone:_____ Cell Phone:_____
Work Phone:_____ Email Address:_____
Please select method of appointment reminders: □ Phone Call □ Text □ Email
SS#(This is required for your visit):_____
Birthdate: _____ Age: _____ Sex: M/F
Marital Status:_____Spouse's Name:_____
Patient's Employer: _____Occupation:_____

In Case of Emergency:_____ Relationship:_____
Phone:_____ Alternate Phone:_____

Responsible Party / Gaurantor of INSURANCE
(If Other Than Patient)

First Name: _____ Last Name:_____
Street Address:_____
City:_____ State:_____Zip Code:_____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email Address: _____
SS#:_____ Date of Birth: _____

Who can we thank for referring you today:

Physician Name_____Internet_____Friend _____Newspaper_____ Other_____

Dr. Bryan Seiff owns this practice at Dover/Lewes locations. This office is a separate entity from the Delaware Eye Institue.

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Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: _____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated

by me in writing.

Signed: _____ Date: _____

Witness: _____ Date: _____

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TOBACCO SMOKER'S INFORMED CONSENT

As a tobacco smoker, I understand that there are increased risks to my health. I have been advised to stop smoking immediately in anticipation of surgery. If I am unable or unwilling to stop smoking, I have been advised to drastically reduce my smoking for one month before and after my surgical procedure.

It has been explained to me, and I understand, that decreased circulation secondary to smoking can cause delays in healing, breakdown and possible death of tissue, loss of skin elasticity and tone, and increased scarring. I have been advised that a smoker can expect to have generally poorer outcomes from a surgical procedure as compared to a non-smoker.

I understand that my surgery may need to be modified to compensate for my smoking and that the surgeon may need to be less aggressive than usual to avoid the complications caused by smoking. These complications still may occur despite the best efforts of the surgeon to avoid them.

I also understand that exposure to second hand smoke can have similar consequences to my health and to my surgical outcome. The adverse effects of smoking and exposure to second hand smoke have been fully explained to me.

I have been advised that smoking cessation classes are available through the American Cancer Society, and that other methods of smoking cessation are available and may be obtained through my primary doctor.

I hereby relieve the Seiff Center for Aesthetic and Reconstructive Surgery as well as my surgeon and anesthesia provider from any responsibility related to the increased risks caused by my smoking habit.

Never Smoked _____initials

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date