Colen MD
Plastic Surgery

PATIENT DEMOGRAPHICS

Patient Name: ______________________________

Patient's Address: ______________________________

City: ____________________ **State:** __________ **Zip:** __________

Home Phone #: (_____)______________ **Cell #:**(_____)______________

Date of Birth: _____ /_____ /_____ **Age:** __________ ☐ **Male** ☐ **Female**

Social Security #: _____-_____-_____ **Email:** ______________________________

Marital Status: ☐Single ☐Married ☐Widow ☐Other: __________

Race: ☐Caucasian ☐African-American ☐Hispanic ☐Asian ☐Other: __________

Ethnicity / Nationality: ______________ **Primary Language:** ______________

Who referred you to our facility?

☐ Friend / Relative
☐ Physician
☐ Insurance Company
☐ Other: ____________________ **Phone #**(_____)______________

Medical Doctor's Name/ Primary Care Physician: ______________________________

Address: ______________________________ **Phone #**(_____)______________

Pharmacy Name: ____________________ **Pharmacy Phone:** (____)______________

Pharmacy Address: ______________________________

\- **INSURANCE INFORMATION** -

Primary Insurance Company Name : ______________________________

Phone Number #(_____)______________ ID # ______________

Policyholder Name: ______________ DOB____/____/____ Relationship ______________

Guarantor's Employer: ______________________________ Work #(_____)______________

Secondary Insurance Company Name: ______________________________

Phone Number #(_____)______________ ID # ______________

Policyholder Name : ______________ DOB____/____/____ Relationship ______________

Guarantor's Employer: ______________________________ Work #(_____)______________

____ **Date** _____/_____/_____

(Patient or Guardian's Signature)

Colen MD Plastic Surgery

Patient Disclosure Consent

HIPAA privacy rules give individuals the right to request a restriction of uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications or that communications be made via alternative means such as sending information to the individuals' place of employment instead of their home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER *(check all that apply)*

- ☐ Home telephone # ______________________________
  - ☐ OK to leave a detailed message.
  - ☐ Leave a message with a callback number ONLY.
- ☐ Work telephone # ______________________________
  - ☐ OK to leave a detailed message.
  - ☐ Leave a message with a callback number ONLY.
- ☐ Cell Phone #______________________________
  - ☐ OK to leave a message with detailed information.
  - ☐ Leave a message with a callback number ONLY.
- ☐ Emergency Contact Person : ______________________

  Phone # ______________________
  - ☐ OK to leave a message with detailed information.
  - ☐ Leave a message with a callback number ONLY.

- ☐ Alternate telephone # ______________________________

PRIVACY RULES REQUIRE US TO TAKE REASONABLE STEPS TO LIMIT THE USE OR DISCLOSURE OF YOUR INFORMATION TO THE MINIMUM NECESSARY TO ACCOMPLISH THE INTENDED PURPOSE USES, AND DISCLOSURES ARE PERMITTED WITHOUT PRIOR CONSENT IN AN EMERGENCY.

____

Signature Print Name Date

Colen MD
Plastic Surgery

Kari L. Colen, M.D.
Stephen R. Colen, M.D., D.D.S
20 Prospect Avenue
Suite 903
Hackensack, NJ 07601

Patient Name:

____

Last First Middle

I request that payment of authorized insurance benefits be made on my behalf to Kari L. Colen, M.D. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THE INSURANCE POLICY(S)** mentioned herein and attached hereto. I authorize any holder of my medical information and records to release to the health care financing administration and its agents, or any insurance company and any information needed to determine these benefits payable for the related services.

IF MY CURRENT POLICY PROHIBITS DIRECT PAYMENT TO THE DOCTOR, I HEREBY INSTRUCT AND DIRECT YOU TO MAKE OUT THE CHECK TO ME AND MAIL IT AS FOLLOWS:

Colen MD Plastic Surgery
20 Prospect Avenue
Suite 903
Hackensack, NJ 07601

If applicable, I hereby authorize the Colen MD Plastic Surgery to commence arbitration and/or litigation proceedings against the appropriate insurance carrier and/or initiate a complaint to the Insurance Commissioner for any reason on my behalf in order for said provider to obtain payment for services furnished to me.

I understand and agree that this assignment does not discharge my responsibility in the event that my insurance company does not make payment and that I am financially responsible for the fees for services rendered.

A photocopy of this Assignment shall be considered as effective and valid as the original.

Patient Signature:____ Date____________

Guardian Signature:____ Date ____________
(If patient is a minor)

Print Name: ________________________________ Relationship to Patient ______________

Witness Signature:____ Date____________

Colen MD
Plastic Surgery

Helen Colen, MD PC
Stephen Colen, MD PC
Kari Colen, MD PC

Patient Name : ____________________

Patient Account # ____________ Date of Service ____________

I hereby affirm that I am the person responsible for payment of the services rendered on above mentioned date of service. I currently either do not have any insurance coverage, my in-network or out-of-network deductible requirements are high, or the services being rendered are not a covered service under the terms of my insurance plan. It has been explained to me and I understand that the amount I am paying today is less than the usual and customary charge for these services. A discount has been applied because the normal cost of these services would create a hardship on my present financial situation. I further understand that should it become apparent that these services may be covered by an insurance plan, the Center may bill my insurance company their usual and customary fees. Any reimbursement from an insurance company up to the amount I am paying today will be owed to me, any amount in excess of what I am paying today will be owed to the respective provider of service.

____________________ ____________
(Signature of Patient) *(Date)*

____
(Print Patient Name)

Relation to Patient: [ ] Self [ ] Parent/ Guardian [ ] Other ____________

Received By: ____________________ ____________
(Employee) *(Date)*

Amount Paid $ ____________

Method of Payment:

[ ] Cash [ ] Check # ________ [ ] Credit Card Authorization # ____________

Colen MD
Plastic Surgery

KARI L. COLEN, M.D.
Plastic & Reconstructive Surgery
Hackensack University Medical Center
20 Prospect Ave., Suite 903
Hackensack, NJ 07601

Phone: 551-228-2208
Fax: 551-228-2210

KLC@ColenMD.com
www.ColenMD.com

Patient History

Name: ______________________________ Date: ______________

Age: ________

Procedure / Reason for Visit:

____

____

Are you currently under the care of, or do you have an Internist / Family Physician? Yes _______ No _______

Name of Physician: ______________________ Phone: ______________________

Address: ____

Vitals

Height: _______ Weight: _______ BMI: _______ B/P: _______

Past Medical History

- ☐ No History
- ☐ Asthma
- ☐ Abnormal Chest Xray
- ☐ Ankle Swelling
- ☐ Arthritis
- ☐ Back Injury
- ☐ Bleeding Disorder
- ☐ Blood Clots in Legs
- ☐ Breast Cancer
- ☐ Broken Bones
- ☐ Bruising
- ☐ Cancer
- ☐ Chest Pain / Tightness
- ☐ Chronic Cough
- ☐ Confusion
- ☐ Congestive Heart Failure
- ☐ Diabetes
- ☐ Dizziness
- ☐ Eczema
- ☐ Emphysema
- ☐ Facial Injury
- ☐ Fainting
- ☐ Head or Neck Injury
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol

- ☐ HIV
- ☐ Hives
- ☐ Irregular Heartbeat
- ☐ Joint Replacement
- ☐ Kidney Stones
- ☐ Leg Pain
- ☐ Lupus
- ☐ Migraine
- ☐ Mitral Valve Prolapse
- ☐ Muscle Weakness
- ☐ Numbness of Arms or Legs
- ☐ Pacemaker
- ☐ Positive TB Test
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Skin Cancer
- ☐ Skin Disease
- ☐ Stroke / TIA
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Urinary Tract Infection
- ☐ Xray Therapy

If yes, please explain:

____

____

____

____

Surgical History

Surgery / Hospitalization	Date	Anesthesia Complications	Notes
		Y / N	
		Y / N	
		Y / N	
		Y / N	
		Y / N	
		Y / N	
		Y / N	
		Y / N	

Family History

- ☐ No History
- ☐ Abnormal Bleeding
- ☐ Abnormal Clotting
- ☐ Adopted
- ☐ Anesthesia Problems
- ☐ Autoimmune Disorders
- ☐ Brain Tumor
- ☐ Breast Cancer
- ☐ Cleft Lip
- ☐ Cleft Palate
- ☐ Diabetes
- ☐ Drug Allergies
- ☐ Endocrine disease
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Hemophilia
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Cancer
- ☐ Malignant Hyperthermia
- ☐ Other Cancer
- ☐ Ovarian Cancer
- ☐ Prostate Cancer
- ☐ Skin Cancer
- ☐ Skin Disease
- ☐ Substance Abuse
- ☐ Von Willebrand

If yes, specify family member afflicted:

____

____

____

____

Allergies & Medications

Allergies

- ☐ Adhesive Tape Reaction: ____________________
- ☐ Codeine Reaction: ____________________
- ☐ Cortisone Reaction: ____________________
- ☐ Iodine Reaction: ____________________
- ☐ Latex Reaction: ____________________
- ☐ Penicillin Reaction: ____________________
- ☐ Shellfish Reaction: ____________________

Type (Other)	Reaction

Medications

Drug	Dose	Frequency	Prescribed By

Social History

Alcohol:

- ☐ Denies use
- ☐ Social use
- ☐ Daily use
- ☐ History of alcoholism

Illegal Drugs:

- ☐ Denies use
- ☐ Admits use
- ☐ History of drug abuse

STD:

- ☐ Denies History
- ☐ Admits History

Tobacco:

- ☐ Non-user
- ☐ Former Smoker
  - ☐ How long did you smoke? ____________________
  - ☐ When did you quit? ________________________
- ☐ Current Smoker
- ☐ Current Smokeless User

Patient Ability to Heal

- Does your skin appear fragile, burns easily? Yes / No
- Do you form thick or raised scarring from a cut or burn? Yes / No
- Do you wax or use depilatories on your face? Yes / No
- Do you ever get cold sores? Yes / No

Female Questions

- Do you have regular periods? Yes / No / NA
- Are you going through menopause? Yes / No / NA
- Are you pregnant or lactating? Yes / No / NA
- During pregnancy, did you ever get hyperpigmentation or masking? Yes / No / NA

Medical History Verification

All information provided above is accurate and complete to the best of my knowledge.

Patient Initials: ______________ Parent / Guardian Initials: ______________ Date: ______________

Nurse Signature: ____