New Patient Information

Name ______________________________

How should we address you? ______________________________

Age __________ Sex __________ DOB __________ SS# __________

Address ______________________________

City __________ State __________ Zip __________

Home # __________ Work # __________ Cell # __________

Email address ______________________________

Marital status: ☐ married ☐ single ☐ divorced Spouse's name __________

Occupation __________ Employer __________

Reason for consultation/Areas of concern: ______________________________

____

____

Whom may we thank for this referral? ______________________________

Name ______________________________

Address ______________________________

☐ Friend ☐ Doctor ☐ Former Patient

Parent/spouse/guardian

Name ______________________________

Address ______________________________

City __________ ST ____ Zip ____

HM (   ) __________ WK (   ) __________

Emergency contact

Name ______________________________

Relationship ______________________________

Phone (   ) ______________________________

Guarantor

Name ______________________________

Relationship ______________________________

Address ______________________________

City __________ ST ____ Zip ____

HM (   ) __________ WK (   ) __________

DOB __________ Sex ____

Employer ______________________________

Phone (   ) ______________________________

Financial responsibility

☐ I will be responsible for all financial charges

☐ The guarantor will be responsible for all financial charges

I certify the above information is correct to the best of my knowledge. I understand that I am financially responsible for all charges whether or not covered by insurance. I also have received the Notice of Financial Policies on the date(s) signed.

Signature ______________________________ **Date** __________

Medical History

Name: ______________________ DOB: ____________

Height: ______ ft ______ in Weight: ________ lbs ___ Age: ____________

When was your last physical exam? ______________________

Chest Xray: ____________ EKG: ____________ Blood work: ____________

Do you have any known allergies? ☐ Yes ☐ No if yes, what medication and describe the reaction :

____

Have you ever had any previous cosmetic or surgical procedures? If yes describe:

Year	Procedure	Physician	were you satisfied?

Do you smoke? ☐ Yes ☐ No

If yes, how many packs/day? _____

for how long? ____________

Do you drink? ☐ Yes ☐ No

If yes, how many drinks/week? _____

Medications

Are you taking prescriptions for the listed conditions?

	Yes	No	Medications
Diabetes	☐	☐	
Anemia	☐	☐	
Sleep	☐	☐	
Asthma	☐	☐	
Thyroid	☐	☐	
High blood pressure	☐	☐	
Heart disease	☐	☐	
Fever blisters	☐	☐	

Are you taking any of the following medications?

	Yes	No	Amount/Frequency
Aspirin	☐	☐	
Ibuprofen	☐	☐	
Birth control	☐	☐	
Hormone replacement	☐	☐	
Chronic steroids	☐	☐	
Pain pills	☐	☐	
Vitamins	☐	☐	
Herbal supplements	☐	☐	

Please list additional medications that you are taking:

____

____

Medical Conditions

Please list any medical condition that you currently suffer from, or have experienced in the past:

	Yes	No	Please describe:
Angina/Chest pain	☐	☐	
Anemia	☐	☐	
Arthritis	☐	☐	
Asthma	☐	☐	
Cancer	☐	☐	
Heart disease	☐	☐	
High Blood Pressure	☐	☐	
Diabetes	☐	☐	Type I Type II
Colitis/IBD	☐	☐	
Hepatitis A/B/C	☐	☐	
HIV/AIDS	☐	☐	
Kidney disease	☐	☐	
Psychiatric disorder	☐	☐	
Depression	☐	☐	
Anxiety	☐	☐	
Seizures	☐	☐	
Thyroid disease	☐	☐	
Lung disease	☐	☐	
Shortness of breath	☐	☐	
Ankle swelling	☐	☐	
Bleeding disorder	☐	☐	
Blood clots	☐	☐	
Anesthesia problems	☐	☐	
Weight loss	☐	☐	
Breast cancer	☐	☐	

Other: ______________________

____

____

Please include any additional information that we should know to better care for you:

____

____

____

____

I confirm that the above is true and accurate to the best of my knowledge.

Signature ______________________ Date ____________

Reason for Consultation

PLEASE CHECK ONE OR MORE OF THE AREAS THAT MOST CONCERN YOU:

FACE	SKIN
☐ Face	☐ Botox
☐ Eyes	☐ Fillers
☐ Brow	☐ Photofacial
☐ Neck	☐ ChemicalPeel
☐ Nose	☐ Lesion/Moles
☐ Chin	☐ ScarRevision
☐ Lips	
☐ Ears	

How long has this been a concern?

What have you done to address this concern this in the past?

Describe the treatments (including dates for surgeries):

Are there any other areas of concern that you would like to discuss?

Patient Medical Insurance Information

It is not necessary to fill out this form if the surgery you are discussing is strictly cosmetic. If insurance will apply to the surgery, please complete the following information and have the receptionist photocopy your insurance card.

ALL INSURANCE PATIENTS SHOULD SIGN BOTH PLACES DESIGNATED AT THE BOTTOM OF THE PAGE.

PRIMARY INSURANCE

Primary Insurance: ______________________________

Address & Phone # of Ins. Co: ______________________________

Name of Insured: ______________________________

Address (if different from patient): ______________________________

Insured's Employer: ______________________________

Insured's ID or SS#: ______________ Group/Policy#: ______________

SECONDARY INSURANCE

Does The Patient Have Additional Insurance Coverage? ______________

If yes, name of Insurance Co: ______________________________

Address & Phone # of Ins. Co: ______________________________

Name of Insured: ______________________________

Address (if different from patient): ______________________________

Insured's Employer: ______________________________

Insured's ID or SS#: ______________ Group/Policy#: ______________

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to the undersigned physician for services described.

Signature: ______________________________ Date: ______________

(Insured/Authorized Person)

RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process claims and/or predetermination letters. This authorization will apply for 2 years from the date listed below.

Patient's signature: ______________________________ Date: ______________

(or guardian, if a minor)

Patient Consent & Acknowledgement of Receipt of Privacy Notice

I understand that as a part of the provision of healthcare services, Dr. Joel Kopelman, create and maintain health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment and any other plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carryout treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions,etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purpose of treatment, payment and healthcare operations. I have the right to revoke this consent, inwriting, except where disclosures have alreadymade in reliance on my prior consent.

This consent is given freely with the understanding that:

- Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.
- A photocopy or fax of this consent is as valid as the original
- I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information and agree to terminate any restrictions in writing on the use and disclosures of my Protected Health Information which have been previously agreed upon.

Patient's name: ______________________________ Date: ________________
(print) (expires in 2 years)

Patient's signature: ______________________________ SS#: ________________
(or guardian, if a minor)

I AUTHORIZE THAT MESSAGES FOR PATIENT PERTAINING TO APPOINTMENTS AND INSTRUCTIONS REGARDING PATIENT CARE MAY BE LEFT :

- ☐ at work
- ☐ cell phone
- ☐ with spouse
- ☐ at home/voicemail
- ☐ via email
- ☐ other relative

Directions to Office:

ROUTE 17 NORTH
Take Ridgewood Avenue – Ridgewood exit toward Ridgewood.
Head west over Route 17 towards Ridgewood. Go past one traffic light (Paramus Road) and our office is the second building on the left. We are directly across the street from the duck pond. Dr. Kopelman's office is on the east wing of the building, we are the first office on the right. The Ridgewood Ambulatory and Lasser Center is located through the front main entrance, first office on the right.

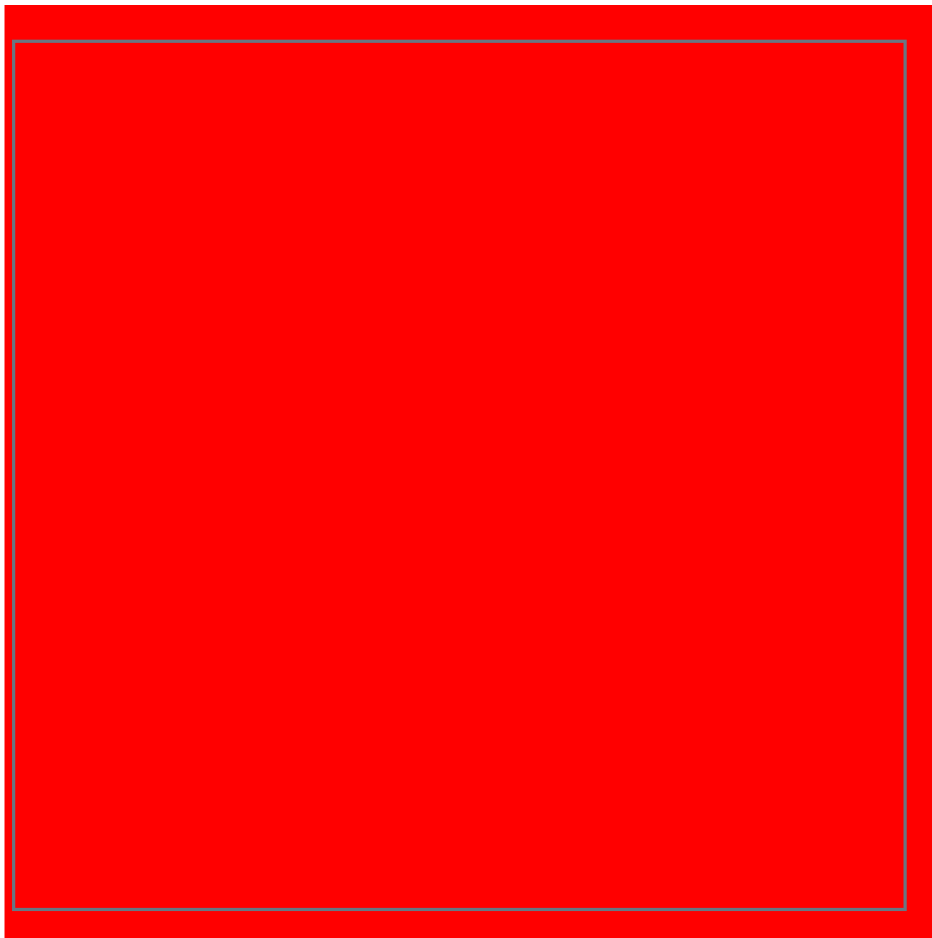
GARDEN STATE PARKWAY (GSP)
Follow to exit 163 (Route 17 North) and proceed as above.

ROUTE 80 WEST
Take local lanes and exit 17 North. Follow directions for GSP.

ROUTE 80 EAST
Exit GSP North. Follow directions for the GSP as above.

GEORGE WASHINGTON BRIDGE
Route 4 West to Route 17 North. Follow directions for Route 17 North as above.

GLEN ROCK OR PATERSON AREA
Take Maple Avenue North to Ridgewood Avenue. Right turn on Ridgewood Avenue. Three traffic lights to 1200 E. Ridgewood Avenue. Office building is on the right hand side across from the duck pond.



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