MILFORD MD
Cosmetic Dermatology Surgery & Laser Center
Pocono Medical Care, Inc.
www.milfordmd.com

PATIENT REGISTRATION FORM

Please present your Insurance/Medicare cards and driver's license or other photo ID upon registration.
Please print the information requested below.

Name: (last) _____ (first)_____ (m)_____

How would you like to be addressed? _____ □ Male □ Female

Age:_____ **Birth Date:**_____ **SS:**_____ **Marital Status:** □ M □ D □ W □ S □ Partnered

Mailing Address:_____ _____

City:_____ State: _____ Zip:_____

Physical Address:_____

City:_____ State: _____ Zip: _____

Phone: **Home** _____ **Work** _____ **Cell** _____

E-Mail:_____

Race:_____ **Ethnicity:**_____

Occupation: _____ **Employer:** _____

Preferred Pharmacy: _____ **Phone:** _____

Emergency Contact: _____ Phone: _____

Nearest relative not living with you: _____ Phone: _____

Address: _____

Primary Health Insurance: _____ Secondary: _____

Payment: If we do not participate with your insurance or if you have not presented your insurance card, you will pay the facility's regular rates, in full, at the time of service. If we participate with your insurance company, **co-pays and deductibles must be paid at the time of service** and your primary insurance company will be billed. You are responsible for billing any secondary insurance you may have and are responsible for any additional monies owed after we receive your insurance company's payment (e.g. non-covered services). Our professional services are rendered for and charged directly to you, not your insurance company and you agree to be responsible for payments. Payment may be made by **CASH, CHECK OR CREDIT CARD**. If we are not a participating provider, a receipt will be given to you, suitable for you to submit to your insurance carrier. **You agree that cosmetic services will not be billed to your insurance company and that you are responsible for full payment before or at the time of service.**

Outside Services: Independent outside laboratory services (e.g. Quest Diagnostics) will bill you directly for any lab work. A cardiology and/or radiology group may provide an interpretation and will bill you directly for any in office testing (e.g. ultrasounds, echocardiograms).

Signature on File: I, the undersigned, request that payment of Insurance/Medicare benefits be made on my behalf to Pocono Medical Care, Inc. for any services rendered to me by this practice and its physicians. I authorize any holder of medical information about me to release to my health insurance company or the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I acknowledge receipt of a copy of this office's *Notice of Privacy Practices* (HIPAA) and *Payment Policy*, consent to receive calls at the number(s) provided above, consent to examination and treatment and agree to be financially responsible for the services rendered.

Patient/Parent/Guardian Signature:_____ Date:_____

Relationship:_____

Today's Date:_____

MilfordMD Cosmetic Dermatology Sugery & Laser Center

Name _____ DOB _____

● **CHIEF COMPLAINT:** ***(DESCRIBE SYMPTOM(S) OR CONDITION(S) FOR WHICH YOU ARE SEEING THE DOCTOR)***

_____

● **PRESENT/PAST MEDICAL HISTORY:** ***(LIST CONDITIONS AND DATE)***

_____

_____

SURGICAL HISTORY: ***(LIST TYPE, REASON FOR SURGERY, DATE, SURGEON)***

_____

_____

● **DRUG ALLERGIES:** (LIST TYPE OF REACTION)

☐ **ANESTHETICS**_____ ☐ **ASPIRIN**_____

☐ **CODEINE**_____ ☐ **ERYTHROMYCIN**_____

☐ **PENICILLIN**_____ ☐ **SULFA**_____

☐ **TETRACYCLINE**_____ ☐ **OTHERS,** ***please list***_____

● **NON-DRUG ALLERGIES:** ☐ **LATEX** ☐ **OTHER** ***(SPECIFY)***_____

PRE-MEDICATION REQUIRED PRIOR TO SURGERY ☐ **NO** ☐ **YES -** ***List drug, dosage & duration***_____

● **ARE YOU CURRENTLY TAKING MEDICATION?** ☐ **YES** ☐ **NO**

If so, please list your medications, drugs, or over the counter preparations/remedies?

MEDICATION	DATE STARTED	DOSAGE (Milligrams)	HOW OFTEN

DO YOU HAVE A PACEMAKER OR INTERNAL DEFIBRILLATOR? ☐ **YES** ☐ **NO**

● **SOCIAL HISTORY:** ***(CHECK ALL THAT APPLY)***

Do you smoke? ☐ **NO** ☐ **YES - Frequency**_____ **Do you use recreational drugs?** ☐ **NO** ☐ **YES - Frequency**_____

Do you drink alcohol? ☐ **NO** ☐ **YES - Frequency**_____ **Hobbies**_____

● **FAMILY HISTORY:**

MOTHER: ☐**living** ☐**deceased / age**_____**FATHER:** ☐ **living** ☐**deceased / age** _____

BROTHERS/SISTERS - ages: _____ **NUMBER OF CHILDREN & ages**_____

CHECK THE FOLLOWING MEDICAL CONDITIONS THAT HAVE OCCURRED IN YOUR FAMILY:

DISEASE	MOTHER	FATHER	BLOOD RELATIVE
Allergies	☐	☐	☐
Arthritis	☐	☐	☐
Asthma	☐	☐	☐
Cancer	☐	☐	☐
Diabetes	☐	☐	☐
Eczema	☐	☐	☐
Hayfever	☐	☐	☐

DISEASE	MOTHER	FATHER	BLOOD RELATIVE
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
Lung Disease	☐	☐	☐
Malignant Melanoma	☐	☐	☐
Psoriasis	☐	☐	☐
Skin Cancer	☐	☐	☐
Tuberculosis	☐	☐	☐

Today's Date:_____

MilfordMD Cosmetic Dermatology Sugery & Laser Center

Name _____ DOB _____

REVIEW OF SYSTEMS AND PAST MEDICAL HISTORY: ***(INDICATE ALL BELOW THAT APPLY; USE C. IF CURRENT, USE P IF PAST)***

CONSTITUTIONAL SYMPTOMS:

____ Fever ____ Hair loss
____ Weight loss ____ Weight gain
____ Chills ____ Tremor
____ Nutritional Deficiencies
____ Other, specify_____

EYES:

____ Cataracts ____ Glaucoma
____ Eyestrain ____ Blurring
____ Inflammation
____ Wear glasses
____ Wear contacts
____ Other, specify_____
Date of last eye exam_____

EARS, NOSE, MOUTH, THROAT:

____ Hearing difficulty
____ Pain ____ Discharge
____ Tinnitus (ringing in ears)
____ Dizziness ____ Wear hearing aid
____ Sinusitis ____ Postnasal drip
____ Obstruction
____ Gum Disease
____ Chronic sores
____ Herpes simplex infections
____ Soreness ____ Redness
____ Hoarseness
____ Other, specify_____

CARDIOVASCULAR:

____ Stroke ____ Palpitation
____ Pacemaker/Defibrillator
____ Heart Attack (MI)
____ Rheumatic Fever
____ Faintness ____ Pain
____ High blood pressure
____ Heart surgery
____ Edema (swelling)
____ Heart valve replacement
____ Other, specify_____

INFECTIOUS:

____ HIV Positive ____ AIDS Virus
____ Hepatitis

RESPIRATORY:

____ Asthma ____ Chest pain
____ Emphysema ____ Tuberculosis
____ Lung disease
____ Breathing disorder
____ Bronchitis, chronic
____ Sputum, with blood
____ Cough, chronic
____ Upper respiratory infection, chronic
____ Other, specify_____

GASTROINTESTINAL:

____ Ulcer ____ Pain
____ Nausea ____ Constipation
____ Diarrhea ____ Vomiting
____ Appetite decrease
____ Colon/intestinal disorder
____ Other, specify_____

GENITOURINARY:

____ Discharge ____ Urgency
____ Sores ____ Incontinence
____ Hesitancy
____ Herpes simplex infections
____ Other, specify_____

MUSCULOSKELETAL:

____ Arthritis ____ Lupus
____ Joint pain ____ Lupus of the skin
____ Weakness ____ Joint swelling
____ Joint replacement
____ Cold sensitivity
____ Other, specify_____

INTEGUMENTARY:

____ Scarring/keloids
____ Herpes simplex (cold sores)
____ Acne / Cystic ____ Hives
____ Accutane Use (past or current)
____ □ Skin cancer(s) □ Malignant Melanoma
____ □ Warts □ Contact dermatitis
____ □ Eczema □ Psoriasis
____ Loss of Pigment
____ Other, specify_____

NEUROLOGICAL:

____ Headaches ____ Convulsions
____ Seizures ____ Migraine headaches
____ Epilepsy ____ Fainting spells
____ Memory loss
____ Other, specify_____

PSYCHIATRIC:

____ Stress ____ Depression
____ Nightmares ____ Insomnia
____ Anxiety ____ Suicidal Tendency
____ Treatment of psychological disorder
____ Other, specify_____

ENDOCRINE:

____ Thyroid disorder
____ Diabetes mellitus
____ Excessive hair, face/body
____ Other, specify_____

HEMATOLOGIC/LYMPHATIC:

____ Anemia ____ Bruise easily
____ Blood clots ____ Excessive bleeding
____ Other, specify_____

ALLERGIC/IMMUNOLOGIC:

____ Asthma ____ Frequent infections
____ Allergies ____ Thyroiditis
____ Vitiligo ____ Addison's Disease
____ Pernicious anemia
____ Hay Fever
Other, specify_____

MALES ONLY:

____ Prostatic problems

FEMALES ONLY:

____ Currently pregnant
____ Currently taking oral contraceptives
____ Last Mammogram
____ Last PAP Smear
____ Number of pregnancies
Date of last menses_____

CANCER(S): ***(LIST TYPE, DATE, TREATMENT:***_____

_____

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PAYMENT POLICY

Thank you for choosing Pocono Medical Care, Inc. / MilfordMD Cosmetic Dermatology Surgery & Laser Center as a healthcare provider. We are committed to providing you with quality and affordable health care. Please read this policy, ask us any questions you may have and **sign in the space provided**.

Insurance: Dr. Marina Buckley participates in many insurance plans, including Medicare. If you have a commercial insurance, payment in full is expected at each visit at private rates. If you are not insured by a plan with which we do business, payment in full is expected at each visit. If you are insured by a plan with which we do business but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-Payments and Deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Non-Covered Services: Please be aware that some—and perhaps all—of the services you receive may be non-covered services or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

Proof of Insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims Submission: If the physician you see participates with your insurance plan a claim will be submitted for you. If the physician does not participate with your plan you can submit the receipt to your insurance company on your own. Your insurance company may need you to supply certain information directly. It is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company. We are not party to that contract.

Coverage Changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Non-Payment: If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from the practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, your physician will only be able to treat you on an emergency basis.

Missed Appointments: Our policy is to **charge for scheduled appointments <u>not</u> cancelled or rescheduled within 24 hours prior to the appointment**. These charges of $25.00 for medical office visits, $50.00 for MediSpa services, $150.00 for laser/cosmetic procedure fees up to $999.00, and $500.00 for laser/cosmetic procedure fees from $1,000.00-$4,999.00 **will be your responsibility and billed directly to you**. All laser liposculpture procedures missed appointment charges are outlined in our Surgical Cosmetic Procedure Financial Policy. Please help us to serve you better by keeping your scheduled appointment(s).

Deposits: A deposit will be required to secure your next cosmetic procedure. If the appointment is not cancelled or rescheduled within 24 hours, you will lose your deposit.

Consultation Fee: Within 90 days of your consult, the consultation fee of $150.00 may be applied to any single procedure or combined procedures totaling $500.00 or more if performed on one day.

Refunds: Any credit card refund will be less a 5% processing fee. Refunds made for amounts paid by check will be less a 2.5% processing fee.

Return Check Fee: $35.00

Patient Name: _____

Signature: _____ **Date**_____

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Communications Consent

I, _____ consent to receive calls and text messages from Pocono Medical Care, Inc. / MilfordMD Cosmetic Dermatology Surgery & Laser Center for my protected healthcare and other services at the phone number(s) listed on the registration sheet, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system to confirm appointments.

I also consent to receiving e-mails from Pocono Medical Care, Inc. / MilfordMD Cosmetic Dermatology Surgery & Laser Center to confirm my appointment(s) and/or informing me of upcoming seminars and specials.

Please indicate your preferred delivery method(s) for the following communications. Check all that apply for each communication.

	Call Home	Call Mobile	Text	Email
Appointment related, including reminders:	____	____	____	____
Events, including seminars & VIP parties:	____	____	____	____
Special discounts and limited time promotions:	____	____	____	____

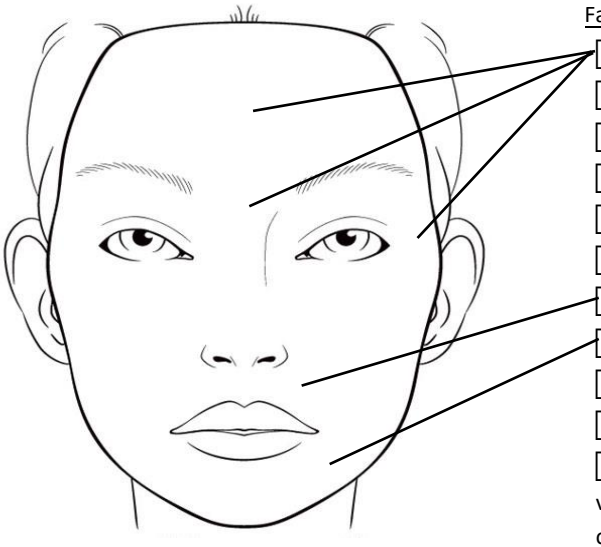
Signature: _____ Date_____

MILFORDMD
Cosmetic Dermatology - Surgery & Laser Center

303 W. Harford Street Milford, Pennsylvania
570-296-4000

Cosmetic Interest Questionnaire

Please fill out this form to help us better understand your aesthetic goals and needs.



- *Mark the items or areas that bother you or you would like to improve.*
- *Feel free to write or draw other things on the face.*
- *Circle the item that is your #1 concern or priority.*

Facial Concerns:

- ☐ Lines in forehead/ between brows/ crow's feet (*sides of eyes*)
- ☐ Under eye- hollowness, lines, pigmentation
- ☐ Flat cheeks/ mid-face volume loss
- ☐ Vertical lip lines ("smokers lines")
- ☐ Lips: shape/ fullness
- ☐ Corners of mouth/ down turned mouth
- ☐ Nose-to- mouth "smile lines" (nasal labial folds)
- ☐ Mouth-to-chin lines (marionette lines)
- ☐ Bumpy looking chin "pebble chin"
- ☐ Double chin
- ☐ Skin color/pigment: uneven pigment, brown spots (sun spots), redness, visible/ broken blood vessels, rosacea, red dots (angiomas), other_____ (circle items of concern)
- ☐ Skin texture: dull skin, rough/uneven texture, large pores, clogged pores, fine lines, wrinkles, scars, laxity, other_____
- ☐ Drooping eyelids
- ☐ Sagging / misshaped ear lobes

Body Concerns:

- ☐ Hair loss / hair thinning
- ☐ Skin laxity / loose skin
- ☐ Excess / stubborn fat
- ☐ Cellulite
- ☐ Size or shape of buttocks
- ☐ Size or shape of breasts
- ☐ Vaginal structure / strength
- ☐ Vaginal Dryness / Urine Leakage
- ☐ Unwanted Tattoos
- ☐ Loss of volume in hands
- ☐ Unwanted moles / skin tags
- ☐ Unwanted hair on face or body

****

Have you done any previous cosmetic/ medical skin care treatments or procedures? ☐ No/ ☐ Yes

If Yes, please explain:_____

Would you like to learn more about: ☐ Skin care advice ☐ Sunscreens ☐ Skin care products
☐ Dermaplaning ☐ Facials ☐ Hydrafacials Other_____

Please use the space below for additional questions / concerns:

Print Name _____ **Age**_____ **Date**_____

Email _____ **Phone #** _____