PATIENT REGISTRATION

Please complete the following confidential information

IF THIS APPOINTMENT IS FOR YOUR CHILD – START HERE

CHILD'S NAME ______________________ (FIRST / M.I. / LAST) PREFERS TO BE CALLED ______________________

ADDRESS ______________________ (STREET / CITY / STATE / ZIP) HOME PHONE ______________________

DATE OF BIRTH ______________ AGE ________ ☐ MALE ☐ FEMALE PARENT/GUARDIAN ______________________

IF THIS APPOINTMENT IS FOR YOU – START HERE

NAME ______________________ (FIRST / M.I. / LAST) PREFERS TO BE CALLED ______________________

ADDRESS ______________________ HOME PHONE ______________________

CITY ______________ STATE ________ ZIP ________ CELL PHONE ______________________

EMAIL ______________________ SOCIAL SECURITY# ________ - ________ - ________

DATE OF BIRTH ______________ AGE ________ ☐MALE ☐FEMALE / ☐MARRIED ☐SINGLE ☐DIVORCED ☐WIDOWED

OCCUPATION ______________________ EMPLOYER'S NAME ______________________

WORK ADDRESS ______________________ (STREET / CITY / STATE / ZIP) WORK PHONE ______________ OK TO CALL WORK ☐ YES ☐ NO

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR A RELATIVE A PATIENT AT OUR OFFICE? ______________________

NAME ______________________ RELATIONSHIP ______________________

WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE? ______________________

MEDICAL DOCTOR ______________________ PHONE ______________________

NAME OF PREFERRED PHARMACY ______________________ LOCATION ______________________

PERSON TO CONTACT IN CASE OF EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME ______________ RELATIONSHIP ______________ WORK # ______________ HOME# ______________

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT ☐ SAME AS PATIENT

NAME ______________________ (FIRST / M.I. / LAST) RELATIONSHIP ______________ SS# ________ - ________ - ________

ADDRESS ______________________ (STREET / CITY / STATE / ZIP) HOME PHONE ______________________

SPOUSE'S NAME ______________________ (FIRST / M.I. / LAST) SPOUSE'S DATE OF BIRTH ______________________

SPOUSE'S EMPLOYER ______________________ SPOUSE'S OCCUPATION ______________________

SPOUSE'S WORK ADDRESS ______________________ (STREET / CITY / STATE / ZIP) WORK PHONE ______________ OK TO CALL WORK ☐ YES ☐ NO

MEDICAL INSURANCE

INSURANCE COVERAGE ☐ YES ☐ NO

INSURANCE COMPANY
- NAME ______________________
- GROUP/PROGRAM NO. ______________________

SUBSCRIBER'S
- NAME ______________________
- DATE OF BIRTH ______________________
- SS# ______________________

PATIENT'S RELATIONSHIP TO SUBSCRIBER
☐SELF ☐ SPOUSE ☐ DEPENDENT

SECONDARY COVERAGE ☐ YES ☐ NO

INSURANCE COMPANY
- NAME ______________________
- GROUP/PROGRAM NO. ______________________

SUBSCRIBER'S
- NAME ______________________
- DATE OF BIRTH ______________________
- SS# ______________________

PATIENT'S RELATIONSHIP TO SUBSCRIBER
☐SELF ☐ SPOUSE ☐ DEPENDENT

CONFIDENTIALITY

NAME(S) OF PERSON(S) WHO MAY RECEIVE MEDICAL INFORMATION ______________________

(Please turn over and sign)

CONSENT FOR TREATMENT

1. I consent to the making of videotapes and photographs before, during and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.
2. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I give consent to allow *Oculofacial Plastic and Reconstructive Surgery, Inc.* to obtain my personal medical history and/or medical records for the purpose of carrying out my treatment, payment and health care operations.
3. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that my insurance company will be billed and that I am responsible for all co-payments and deductibles not covered by insurance.
4. I have received a copy of the Notice of Privacy Practices for *Oculofacial Plastic and Reconstructive Surgery, Inc.*

Patient's Signature____ Date ________________________

Parent / Responsible Party's Signature ______________________________________ Relationship to patient __________________

SUMMARY NOTICE OF PRIVACY POLICY PRACTICES

This is a summary of our Notice of Privacy Practices, which describes how we may use and disclose your medical and personal information and how you can have access to this information.

OUR PLEDGE TO PROTECT YOUR PRIVACY

Oculofacial Plastic and Reconstructive Surgery, Inc. is committed to protecting the privacy of your medical and personal information. So that we may best meet your medical needs, we share your medical records with the health care providers involved in your care. We share your information only to the extent necessary to collect payment for the services we provide, to conduct our business operations, and to comply with the laws that govern health care. We will not use or disclose your information for any other purpose without your permission.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

- to inspect and obtain a copy of your medical records with certain limitations;
- to request an amendment or addendum to your medical record;
- to an accounting of *Oculofacial Plastic and Reconstructive Surgery, Inc.'s* disclosures of your medical information;
- to request restrictions on certain uses and disclosures of your medical information;
- to request when and where to contact you;
- to request a copy of the full version of this Notice of Privacy Practices

WE MAY USE AND DISLOSE YOUR PERSONAL AND HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION FOR THE FOLLOWING PURPOSES:

- to provide you with medical treatment;
- to bill and receive payment for the treatment received;
- as requires and permitted by law
- for functions necessary to run the office of *Oculofacial Plastic and Reconstructive Surgery, Inc.* and assure that our patients receive quality care;
- for public health activities (e.g. reporting abuse);
- for research purposes in limited circumstances;
- to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes;
- to a court or administrative order, subpoena, discovery request or other lawful process;
- to a health oversight agency, such as the California Department of Health Services;

We reserve the right to change our privacy practices and update this Notice accordingly. Please see our full Notice of Privacy Practices for a more detailed description of our privacy practices. For further information about the full Notice of Privacy Practices, please contact *Oculofacial Plastic and Reconstructive Surgery, Inc.'s* Privacy Officer in writing at 210 Hospital Circle Suite C, Westminster, California 92683.

I have read and understood my rights and *Oculofacial Plastic and Reconstructive Surgery, Inc.'s* Privacy Standards.

______________________________________ ________________________________ ________________

Signature of Patient or Legal Representative | If Legal Representative, indicate relationship to patient | Date