MORGENSTERN CENTER
for Orbital and Facial Plastic Surgery

123 Bloomingdale Avenue, Suite 102, Wayne, PA 19087
Phone 610-687-8771 Fax: 610-687-8773 www.MorgensternCenter.com

PATIENT REGISTRATION

DEMOGRAPHIC INFORMATION

***Last Name:**_____ ***First Name:**_____ **MI:**_____ **Suffix:**_____

***Date of Birth:**_____ **Age:**_____ **Sex:**_____ ***Social Security #:**_____

***Address:**_____

***City:**_____ ***State:**_____ ***Zip:**_____

Home Phone: _____ **Cell Phone:**_____ **Marital Status:**_____

***E-Mail:**_____

Preferred Method of Contact: Home Phone Cell Phone E-Mail Mail

Ethnicity:_____ **Race:**_____ **Preferred Language:**_____

Employer Name:_____ **Occupation:**_____

Employer Address: _____

EMERGENCY CONTACT INFORMATION

***Emergency Contact Name:**_____

***Relationship to Patient:**_____

***Emergency Contact Home Phone:** _____ **Emergency Contact Cell Phone:**_____

*Do we have your permission to discuss medical information with this person? **Y N**

Referring Provider:_____
Phone:_____

Primary Physician:_____ **Phone:**_____

Cardiologist (if applicable): **Phone:**

PHARMACY INFORMATION

***Pharmacy Name:**_____ **Pharmacy Phone:**_____

***Pharmacy Address:**_____

Do you have any drug or Latex allergies? Yes No
If yes, please list and include reaction:

DOUBLE SIDED

Are you currently taking any medications? (includes OTC, prescription, vitamins and supplements) Yes No
If yes, please list all medications:

Medication Name	Dosage	Frequency

Past Surgical History (including eye surgeries): ☐ Check if not applicable

Type of Surgery	Date

Have you ever been vaccinated for the following:

Influenza (Flu)	Yes No	Date:	_____
Pneumonia	Yes No	Date:	_____
Meningitis	Yes No	Date:	_____
Varicella (Chicken Pox/Shingles)	Yes No	Date:	_____

Has anyone in your direct family (father, mother, sibling) had any of the following: ☐ Check if not applicable

Autoimmune Disorders	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No
Cancer	Yes	No	Heart Failure	Yes	No	Obesity	Yes	No
Clotting Disorders	Yes	No	High Blood Pressure	Yes	No	Stroke/TIA	Yes	No
Diabetes	Yes	No	High Cholesterol	Yes	No	Thyroid Disease	Yes	No
Epilepsy/Seizures	Yes	No	Liver Disease	Yes	No			

Do you have or have you had any of the following:

Anemia	Yes	No	Diabetes Mellitus	Yes	No	Irregular Heart Rate	Yes	No
Angina/Chest Pain	Yes	No	Earaches/Toothaches	Yes	No	Kidney Disease	Yes	No
Arthritis	Yes	No	Emphysema/Chronic Bronchitis	Yes	No	Liver Disease/Hepatitis	Yes	No
Asthma	Yes	No	Epilepsy/Seizures	Yes	No	Long Term Steroid Use	Yes	No
Bladder Difficulties	Yes	No	Fainting Spells / Dizziness	Yes	No	Numbness/Weakness/Paralysis	Yes	No
Bleeding Disorders	Yes	No	Fibromyalgia	Yes	No	Pneumonia	Yes	No
Blood Clot (DVT, PE)	Yes	No	GERD/Acid Reflux	Yes	No	Sinus Trouble	Yes	No
Cancer/Tumor	Yes	No	Headaches/Migraines	Yes	No	Sleep Apnea	Yes	No
Cardiac Pacemaker	Yes	No	Heart Attack	Yes	No	Stroke/TIA	Yes	No
Chronic Pain	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Congestive Heart Failue (CHF, CAD)	Yes	No	High Cholesterol	Yes	No	Thyroid Disease	Yes	No
Depression/Anxiety	Yes	No	HIV/AIDS	Yes	No	Weight Loss/Gain	Yes	No

Have you ever had any medical conditions not listed above? Yes No _____

DOUBLE SIDED

Have you ever smoked? Yes No
If yes, for how long? _____
How much? _____
Are you still smoking? Yes No

Do you drink alcohol? Yes No
If yes, how much? _____
How often? _____

Do you use recreational drugs?	Yes	No	If yes, describe: _____
Do you have bleeding or bruising problems?	Yes	No	If yes, describe: _____
Do you have problems with scarring?	Yes	No	If yes, describe: _____
Do you have any history of problems with anesthesia?	Yes	No	If yes, describe: _____
Are you currently pregnant?	Yes	No	N/A
Date of last menstrual period? _____			N/A

Primary Health Insurance Company:_____

Policy #:_____**Group #:**_____

Referral Required? Y N Copay? Y N

Policyholder's Name:_____**DOB:**_____**Employer:**_____

Secondary Health Insurance Company:_____

Policy #:_____Group #:_____

Referral Required? Y N Copay? Y N

Policyholder's Name:_____DOB:_____Employer:_____

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I authorize The Morgenstern Center to take photographs, slides or videotapes of me or parts of my body for the following procedure(s) and for medical purposes to be used for my care, medical presentations and/or articles.
In addition, I authorize the use of these images, without compensation to me, for the following specific purposes:
(**Please initial in the boxes marked Yes or No for each item**)

Yes	No	Medium
		As proof of medical record for **insurance company coverage** so charges may be submitted for payment *Without this consent, charges will not be submitted to your insurance, instead they will be billed to you the patient*
		In the **office photo album** for patient education
		On our **website** for patient education
		In **printed office materials** for patient distribution
		In **medical lectures** for doctor education

If I have questions about the use/disclosure of my photographs, I can contact the office at 610-687-8771.

Signature:_____ **Date:**_____

DOUBLE SIDED

INSURANCE NOTICE

Your insurance company will only pay for services that it determines to be reasonable and necessary. If your insurance company determines that a particular service, although it would be otherwise covered, is "not reasonable or necessary" under their program standards, they will deny payment for that service.

There is a possibility that your insurance company may consider your procedure/surgery to be cosmetic in nature. Be assured that we will do our best to provide them will all documentation and test results to prove the medical necessity of your procedure. Unfortunately, this does not always guarantee that they will pay for our services. In such cases, we must bill you for the procedure. Conversely, we do not bill your insurance for any procedures that do not meet the insurance allowed criteria for that procedure.

I understand that office visit charges are payable on the day service is rendered. I authorize The Morgenstern Center to bill my insurance company for medically necessary services. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. Any bills left unpaid beyond 30 days will incur a late fee of $25 per month.

*If your insurance plan has a **yearly deductible/copay**, we advise that you check with your insurance company regarding your balance ahead of office appointments and procedures. If you have not met your limit, the deductible out-of-pocket fees for services, including surgeries, will not be paid by your insurance company, even though it is a covered expense, and will be billed to you.*

I authorize The Morgenstern Center to keep my signature on file and to charge my credit card for charges associated with payment agreements and to collect any due payments or debts.

You are responsible for these inquiring about these fees from your insurance company and any payments due to The Morgenstern Center. We will provide any documentation you may need for your inquiry.

I understand that my insurance contract is between The Morgenstern Center and myself.

Signature:_____**Date:**_____

PATIENT PRIVACY CONSENT

I understand that under the Health Insurance Portability and Accountability Act of 1996, I have certain rights to privacy regarding my protected health information (PHI).

I understand that by signing this consent, I authorize The Morgenstern Center to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third-party payers (i.e. my insurance company)
- Healthcare operations (i.e. performance reviews, certification, accreditation and licensure)

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but the office is not required to agree to these requested restrictions. Any restrictions will be reviewed by The Morgenstern Center's HIPAA Compliance Committee and I will be notified of final decision.

I have been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that The Morgenstern Center reserves the right to change the terms of this Notice, and that I may contact the office at any time to obtain the most current copy of this Notice.

I have the right to revoke this Consent, in writing at any time; however, such revocation shall not affect any disclosures The Morgenstern Center has already made in reliance on my prior Consent. Requests will be forwarded to the HIPAA Compliance Committee. I understand that The Morgenstern Center may condition treatment upon execution of the Consent.

Signature:_____**Date:**_____

Printed Name: _____

DOUBLE SIDED