DARRICK E. ANTELL, M.D., P.C.

PATIENT NAME: _____
First Middle Last

BIRTHDATE: ____/____/____ AGE: _____ SS#: _____ _____ _____ SEX: M \ F
MM DD YYYY

ADDRESS: _____
Street Apt # City State Zip

****Please be sure to include your apartment or suite number above if applicable.**

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL: _____

MARITAL STATUS: ☐ Single ☐ Married to: _____ ☐ Other: _____

EMPLOYER AND EMERGENCY CONTACT

PATIENT'S EMPLOYER: _____ OCCUPATION: _____

WORK ADDRESS: _____
Street City State Zip

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

EMERGENCY CONTACT: HOME: _____ WORK: _____ CELL PHONE: _____

REFERRAL INFO AND AREAS OF INTEREST

HOW WERE YOU REFERRED TO DR. ANTELL: _____ HAVE YOU VIEWED HIS WEBSITE: Y/N

WHAT PROCEDURE ARE YOU INTERESTED IN TODAY? (Mark all that apply)

Facial Procedures

- ☐ Blepharoplasty (Eyelid Surgery)
- ☐ Brow or Forehead Lift
- ☐ Chin Augmentation
- ☐ Earlobe Repair
- ☐ Facial Liposuction (Neck, Jowls)
- ☐ Face or Neck Lift
- ☐ Otoplasty (Ear Pinning)
- ☐ Rhinoplasty (Nose Reshaping)

Breast Procedures

- ☐ Breast Augmentation
- ☐ Breast Reconstruction
- ☐ Breast Reduction
- ☐ Gynecomastia
- ☐ Implant Exchange
- ☐ Mastopexy (Breast Lift)
- ☐ Nipple Reduction or Inversion
- ☐ Skin Resurfacing (Peel, Dermabrasion)

Body Procedures

- ☐ Abdominoplasty (Tummy Tuck)
- ☐ Brachioplasty (Arm Lift)
- ☐ Liposuction
- ☐ Lipoma Removal

Non-Surgical Procedures

- ☐ Botox
- ☐ Chemical Peels
- ☐ Fine Line/Wrinkle Fillers

☐ Other Procedures not listed above: _____

I understand that office visits and procedures are payable on the day service is rendered.

Signature: _____ **Date:** _____

Darrick E. Antell, M.D., P.C.
850 Park Avenue
New York, NY 10075
212-988-4040

PHARMACY INFORMATION FORM

Name of Patient:_____

Please provide us with Your Pharmacy Information below
In case we ever need to call anything in for you.

PHARMACY NAME:_____

PHARMACY ADDRESS:_____

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

Telephone Number:_____

DARRICK E. ANTELL, M.D., P.C.

Confidential Record: Information contained here will not be released unless you have authorized us to do so.
Please answer ***ALL*** questions to the best of your knowledge.

PATIENT NAME: _____ REASON FOR VISIT: _____

AGE: _____ HEIGHT: _____ WEIGHT: _____ CURRENT PHYSICIAN(S): _____

HAVE YOU EVER HAD A PROCEDURE BY DR. ANTELL: YES/ NO IF YES, WHICH PROCEDURE _____

LIST ALL PREVIOUS SURGERIES (PLEASE INCLUDE DATE):

LIST ANY SERIOUS ILLNESS AND/OR ACCIDENTS:

DO YOU HAVE OR HAD YOU HAD ANY OF THE FOLLOWING: IF YES, GIVE DATE OF ONSET/OCCURRENCE

Aids/ HIV	○No ○Yes	Epilepsy/Seizures	○No ○Yes	Ulcers	○No ○Yes
Arthritis	○No ○Yes	Facial Pain	○No ○Yes	Pneumonia	○No ○Yes
Asthma	○No ○Yes	Fever Blisters	○No ○Yes	Sinus Problems/Infections	○No ○Yes
Bronchitis	○No ○Yes	Goiter/Thyroid	○No ○Yes	Stroke	○No ○Yes
Cancer	○No ○Yes	Hay Fever/Allergies	○No ○Yes	Tonsillitis	○No ○Yes
Depression	○No ○Yes	Headaches/Migraines	○No ○Yes	Tuberculosis	○No ○Yes
Diabetes	○No ○Yes	Heart Trouble	○No ○Yes		
Dizziness/Vertigo	○No ○Yes	Hepatitis	○No ○Yes		
Ear Infection	○No ○Yes	High Blood Pressure	○No ○Yes		

DO YOU SMOKE: YES ○ NO ○ IF YES, HOW OFTEN: _____ PACK(S)/DAY FOR HOW LONG: _____ YEARS

DO YOU DRINK ALCOHOL: YES ○ NO ○ IF YES, HOW MANY DRINKS: _____ HOW OFTEN: _____

DO YOU USE RECREATIONAL DRUGS: ○YES/ NO○ IF YES, DESCRIBE _____
DO YOU HAVE BLEEDING/BRUISING PROBLEMS: ○YES/NO○ IF YES, DESCRIBE _____
HAVE YOU PREVIOUSLY HAD PROBLEMS SCARRING: ○YES/NO○ IF YES, DESCRIBE _____
HAVE YOU EVER HAD ANY PROBLEMS WITH ANESTHESIA: ○YES/NO○ IF YES, DESCRIBE _____

LIST ALL MEDICATIONS (INCLUDING DOSAGE AND FREQUENCY) YOU ARE PRESENTLY TAKING:

LIST ALL DRUG AND/OR LATEX ALLERGIES:

WOMEN ONLY:

ARE YOU CURRENTLY PREGNANT: YES/ NO ○ ○ NUMBER OF CHILDREN: _____

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

Signature: _____ Date: _____

Darrick E. Antell, M.D., P.C.

Patient Acknowledgement Form & Chaperone Policy

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgement. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy. (See Insert)

At any time, at the request of the patient, we are happy to provide you with a chaperone. Some patients would feel more comfortable having another person in the examination room, in addition to themselves and Dr. Darrick Antell. This may be a friend or family member, or a member of our staff. Your comfort is one of our primary concerns, and we value this. Simply address your request for a chaperone to Dr. Darrick Antell or anyone on our staff, and we will accommodate you.

Chaperone Requested: YES_____ NO_____ (Please initial one choice)

Choosing "Yes" means that you ***REQUIRE*** one of ***Dr. Antell's staff members*** to be present, along with Dr. Antell, during the entirety of your consultation.

Minors must always be accompanied by a parent or legal guardian when a physical examination is performed, or one of Dr. Darrick Antell's staff will be present at the examination. At the minor's request, and with the parent or legal guardian's agreement, the minor may be examined without the parent or legal guardian in the examination room.

On rare occasions, in an emergency, Dr. Darrick Antell may see you after hours in his office or at your home. At such time, no office staff is available to serve as a chaperone. Should such an occasion arise, Dr. Darrick Antell requires that you be accompanied by a family member or friend.

By signing this form you acknowledge that you have been informed of our use and disclosure of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our notice has been provided to you: that you understand the contents of our Notice, how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

_____ _____/_____/_____

Name Date

Darrick E. Antell, M.D.
(NYC Reconstructive Surgery, P.C.)

Insurance

We want to thank you for allowing us to provide your health care. We appreciate your trust in us, and we appreciate the opportunity to serve you. In order to better serve you, we try to contain the ever-rising cost of health care. In an effort to do so, we use the AAAA certified facility, Columbia East Side Ambulatory Surgery Facility, P.C. to perform surgery that would otherwise be much more costly if done in a hospital setting.

There will be a separate charge for Columbia East Side Ambulatory Surgery Facility that will be billed to your insurance company for reconstructive procedures or billed to you for cosmetic procedures.

Insurance may be applicable for some reconstructive and medically necessary procedures. Please indicate your coverage below.

Name of Insurance Company:_____

Policy and Group Number:_____ ○ ○ HMO/PPO

Name of Policy Holder:_____ SS #:_____

****Please provide your insurance card to the receptionist****

Patient's Authorization to Release Medical Information and Claim Payment Authorization: I hereby authorize NYC Reconstructive Surgery, P.C. and Columbia East Side Ambulatory Surgery Facility to release any information, including medical records, regarding services rendered and allow a photocopy of my signature to be used to file for insurance. I hereby authorize Dr. Antell's practice to file appeals to my insurance provider regarding any claim submitted on my behalf.

I hereby authorize and direct payment check(s) for benefits due the doctor for services rendered by Dr. Antell's practice as well as benefits for the use of the accredited operating room facility to be made directly to the practice regardless of my insurance benefits, if any. I grant my power of attorney for his designated representative to pursue these benefits. I understand that I am financially responsible for the fees for services rendered.

Note:
The practice is defined as:
NYC Reconstructive Surgery, P.C. (The professional fee)
Columbia East Side Ambulatory Surgery Facility, P.C. (The facility fee)

I HAVE READ AND FULLY UNDERSTAND THE ABOVE INFORMATION.

_____ _____
Signature of Patient or Authorized Person if a Minor **Date**

AGREEMENT AS TO RESOLUTION OF CONCERNS

We request your agreement ensuring experts chosen for a meritorious case are trained and qualified in the same field as the doctor. This contributes not only to reducing healthcare costs, but increasing access to compassionate care.

"I", "Patient/Guardian" shall be understood to mean _____.
"Physician" shall be understood to mean Dr. Darrick E. Antell and Darrick E. Antell M.D., P.C., and NYC Reconstructive Surgery P.C.

I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice increase the cost and decrease the availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician.

Should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use American Board of Medical Specialties ("ABMS") board-certified expert medical witness(es) in the same specialty as Physician. Furthermore, I agree that these expert witnesses will be members in good standing of the American Society of Plastic Surgery.

Finally, you (the patient) agree that counsel for me (Physician) shall have the right and be free to depose such expert witnesses at least 120 days before any scheduled trial date.

In further consideration for this, I, (the Physician), agree to the same stipulations.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

_____ X_____
Physician Signature Patient/Guardian Signature

_____ X_____
Effective from Date of Treatment Date of Signature

Darrick E. Antell M.D.
Telephone 212-988-4040 **Facsimile** 212-988-0527 850 Park Avenue New York, NY 10075 **Web** www.antell-md.com

Disclosure Information

To Our Patients:

Welcome to the practice, which is owned by Dr. Darrick Antell.

Your Surgeon/Physician: We would like you to know that Dr. Antell is board certified by the American Board of Plastic Surgeons and is licensed in the State of New York. He has been in practice since 1987 and attended University School, Hobart College, Case Western Reserve University Dental School, and the University Of Toledo College Of Medicine. He completed his residency at Stanford University Medical Center in surgery and general surgery and what was then called Cornell Medical Center in plastic and reconstructive surgery. You may request his C.V. which we keep on file. His training is extensive in the field of cosmetic and reconstructive plastic surgery. Should you choose to have surgery at this organization, Dr. Antell will be the only one performing your surgery.

Your Anesthesia Provider: Additionally, this organization utilizes Board Certified credentialed anesthesia providers, with many years of experience and training licensed in the State of New York.

The Team: Our team is made up of competent individuals including Licensed Practical Nurses and Registered Nurses licensed in New York that will assist in providing safe patient care.

Should you have a problem: Please be advised that if you have a grievance or concern the following mechanism exists: Ask for the grievance form from the receptionist. Or you may call the accrediting organization that oversees our compliance with standards of care The Joint Commission on Accreditation of Healthcare Organizations at 800-994-6610 or emailing complaint@jointcommission.org.

Make a suggestion: If you have a suggestion, please place this in writing and hand to the receptionist or mail it to the office.

Play a part in your care: We encourage all patients to be actively involved in their care, so please speak up and ask questions of anyone in this organization.

Additionally, please be advised that this organization does not recognize Do Not Resuscitate orders or Living Wills. If you have any questions, please see the receptionist. If you have a living will or other directive that you would like us to keep a copy of please provide us with a copy of that directive.

If anyone has concerns about patient care and safety in the organization, that the organization has not addressed, you are encouraged to contact the organization's management. If you feel the concerns were not resolved through the organization, you are encouraged to contact the Joint Commission by calling 800-994-6610 or emailing complaint@jointcommission.org.

PATIENT ACKNOWLEDGEMENT OF DISCLOSURE INFORMATION

My signature below acknowledges the following:

- I have received a copy/am aware of the **Patient Bill of Rights**; as required by law and have had an opportunity to receive assistance in understanding and exercising these rights.

- I have received a copy/am aware of this office's **Notice of Privacy Practices**, including the **Private Health Information (PHI)** designated at the time of visit.

- I have received information on/am aware of the Infection Control measures utilized by this organization.

- I have received a copy/am aware of the **Practice Disclosure (about our Practice, including the Grievance process)** and am comfortable with that information. I also understand this practices position on **Do Not Resuscitate (DNR) and Living Wills** and that this practice does not honor these directives.

For Medicare Deemed Status Only:

☐ I have not executed a DNR or Living Will
☐ I have executed a DNR and/or Living Will

Signature of Patient/Representative_____Date_____

Above signature was not obtained because:

☐ Patient is unable and unaccompanied by a representative. Patient left with all pertinent disclosures.

☐ Patient refused to sign.

☐ Patient refused forms.