

## PATIENT REGISTRATION

### PERSONAL INFORMATION

Patient's Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Parent's Name (minors only) \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Street Address \_\_\_\_\_ Email Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ Social Security # \_\_\_\_\_  
Birth Date \_\_\_\_\_ Marital Status S M D W Sex M F  
Family Doctor & Phone # \_\_\_\_\_ Emergency Contact \_\_\_\_\_  
Emergency Contact Phone \_\_\_\_\_

Reason for visit \_\_\_\_\_

May we leave voice mails at the above telephone numbers? YES / NO If so, which? Home / Cell

May we send you emails (i.e. appointment reminders, product and services offerings?) YES / NO

**WHERE DID YOU HEAR ABOUT US (Circle one or more):**

YELLOW PAGES ER PHYSICIAN FRIEND PATIENT SEMINAR WEBSITE OTHER \_\_\_\_\_

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### EMPLOYMENT INFORMATION

Employer \_\_\_\_\_ Phone \_\_\_\_\_  
Street Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

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### HEALTH INSURANCE INFORMATION(If Applicable)

Insurance Company \_\_\_\_\_ Identification & S.S. \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_ Subscriber Date of Birth \_\_\_\_\_

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Would you be interested in receiving a complimentary consultation or information regarding any of the following Spa services? (Please circle all that apply)

Skin Care Analysis	Laser hair Removal	Botox	Restylane	Perlane	Radiesse
Facial Treatments/Peels	Photofacial Treatments	Rytec Portrait Skin Resurfacing	Permanent Make-up/ Skin Needling		
Skin Care Products	Vein Treatments	Waxing/ Eyebrow Shaping	Gift Certificates		

I confirm that the information provided above is correct and I have not withheld any information that may be relevant to my procedure or treatment.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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# MEDICAL HISTORY

Date: \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Sex: \_\_\_\_\_

Race: \_\_\_\_\_

Health History of the Patient	Family History	Review of Systems (Have you recently had or now have)																																																																																																																																																																																																																																																			
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 <input type="checkbox"/> Yes                      <input type="checkbox"/> No</p> <p>Are you:  <input type="checkbox"/> Married                      <input type="checkbox"/> Single  <input type="checkbox"/> Divorced                      <input type="checkbox"/> Widowed</p> <p>Number of Children Living: _____</p> <p>Number of Pregnancies: _____</p> <p>Presently Living Alone?  <input type="checkbox"/> Yes                      <input type="checkbox"/> No</p> <p>Smoke (#) of _____ Packs per Day</p> <p>Alcohol:    <input type="checkbox"/> Never    <input type="checkbox"/> Occasional  <input type="checkbox"/> Moderate to Heavy</p> <p>Drug Overuse:                      <input type="checkbox"/> None  <input type="checkbox"/> Presently                      <input type="checkbox"/> Past Problem</p>		Yes	No	Stroke			Heart Trouble			High Blood Pressure			Diabetes			Arthritis			Gout			Seizures			Mental Illness			Kidney Trouble or Stones			Cancer			Bleeding Disorders			Alcoholism			Other Illnesses			<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">Yes</th> <th style="width: 10%; text-align: center;">No</th> </tr> </thead> <tbody> <tr><td>Reading Glasses</td><td></td><td></td></tr> <tr><td>Change of Vision</td><td></td><td></td></tr> <tr><td>Loss of Hearing</td><td></td><td></td></tr> <tr><td>Ear Pain</td><td></td><td></td></tr> <tr><td>Hoarseness</td><td></td><td></td></tr> <tr><td>Nosebleeds</td><td></td><td></td></tr> <tr><td>Difficulty Swallowing</td><td></td><td></td></tr> <tr><td>Morning Cough</td><td></td><td></td></tr> <tr><td>Shortness of Breath</td><td></td><td></td></tr> <tr><td>Chills or Fever</td><td></td><td></td></tr> <tr><td>Heart or Chest Pain</td><td></td><td></td></tr> <tr><td>Abnormal Heartbeat</td><td></td><td></td></tr> <tr><td>Badly Swollen Ankles</td><td></td><td></td></tr> <tr><td>Calf Cramps with Walking</td><td></td><td></td></tr> <tr><td>Poor Appetite</td><td></td><td></td></tr> <tr><td>Toothache</td><td></td><td></td></tr> <tr><td>Gum Trouble</td><td></td><td></td></tr> <tr><td>Nausea or Vomiting</td><td></td><td></td></tr> <tr><td>Stomach Pain</td><td></td><td></td></tr> <tr><td>Ulcers</td><td></td><td></td></tr> <tr><td>Frequent Belching</td><td></td><td></td></tr> <tr><td>Frequent Loose Bowel Movements</td><td></td><td></td></tr> <tr><td>Blood in Bowel Movements</td><td></td><td></td></tr> <tr><td>Frequent Constipation</td><td></td><td></td></tr> <tr><td>Hemorrhoids</td><td></td><td></td></tr> <tr><td>Frequent Urination (pass water)</td><td></td><td></td></tr> <tr><td>Burning on Urination</td><td></td><td></td></tr> <tr><td>Difficulty Starting Urination</td><td></td><td></td></tr> <tr><td>Difficulty Stopping Urination</td><td></td><td></td></tr> <tr><td>Get Up Every Night to Urinate</td><td></td><td></td></tr> <tr><td>Frequent Headaches</td><td></td><td></td></tr> <tr><td>Blackouts</td><td></td><td></td></tr> <tr><td>Seizures</td><td></td><td></td></tr> <tr><td>Frequent Rash</td><td></td><td></td></tr> <tr><td>Hot or cold Spells</td><td></td><td></td></tr> <tr><td>Recent Weight Change</td><td></td><td></td></tr> <tr><td>Nervous Exhaustion</td><td></td><td></td></tr> <tr><td>Insomnia</td><td></td><td></td></tr> <tr><td>Depression</td><td></td><td></td></tr> <tr><td>Nervous Tension</td><td></td><td></td></tr> <tr><td>Women Only:</td><td></td><td></td></tr> <tr><td style="padding-left: 20px;">Irregular Periods</td><td></td><td></td></tr> <tr><td style="padding-left: 20px;">Vaginal Discharge</td><td></td><td></td></tr> <tr><td style="padding-left: 20px;">Frequent Spotting</td><td></td><td></td></tr> </tbody> </table> <p>Explain all YES Answers on Back:</p> <div style="border: 1px solid black; padding: 2px; text-align: center; margin: 10px 0;"> <b>Advance Directive</b> </div> <p><input type="checkbox"/> I DO                      <input type="checkbox"/> I DO NOT  have an Advance Directive.  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## PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Privacy Notice is being provided to you as a requirement of federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operation and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Dr. Joseph Aguiar, M.D., PA is required by law to provide you our Privacy Notice.

### **I. Uses and Disclosures of Protected Health Information**

Dr. Joseph Aguiar, M.D., PA may use your protected health information (PHI) for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. "PHI" may use or disclose only for these purposes unless Dr. Joseph Aguiar, M.D., PA has obtained authorization. Disclosure of your protected health information for the purposes described in this Privacy Notice may be in writing, orally or by facsimile.

- A. **Treatment.** We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. For example, we may disclose your PHI to a pharmacy to fill a prescription or to a laboratory to order a blood test.
- B. **Payment.** Your PHI will be used, as needed, to obtain payment for the services that we provide. For example, we may need to disclose your information to your health insurance company to get prior approval for a surgery. We may also disclose patient information to another provider involved in your care for the other provider's payment activities.
- C. **Operations.** We may use or disclose you PHI, as necessary, for your own health care operations to facilitate the function of Dr. Joseph Aguiar and to provide quality care to all patients. Health care operations include such activities as; quality assessment and improvement activities.

### **II. Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object**

Federal privacy rules allow us to disclose your PHI without permission or authorization for a number of reasons including the following:

- A. When Legally required
- B. When there are risk to public health
- C. To report suspected abuse, neglect or domestic violence
- D. In connection with judicial and administrative proceedings
- E. For workers compensation

### **III. Your Rights**

- A. The right to inspect and obtain a copy of your PHI
- B. The right to request a restriction on uses and disclosures of your PHI
- C. The right to request amendments to your PHI
- D. The right to receive an accounting by Dr. Joseph Aguiar, M.D., PA of certain disclosures of PHI

### **IV. Complaints**

You have the right to express complaints to Dr. Joseph Aguiar, M.D., PA and to the Secretary of Health and Human services if you believe that your privacy rights have been violated. You may complain to the Privacy Officer verbally or in writing.

(Condensed version of privacy notice)

**Receipt of Notice Of Privacy Practice**

**Written Acknowledgement Form**

I, \_\_\_\_\_, have received a copy of  
Joseph W. Aguiar, MD, PA's Notice of Privacy Practices.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## **EFFECTIVE MARCH 1, 2011**

**Due to an increase in Insurance Plans that have a Co-Pay and a Co-Insurance that is the patient's responsibility, we are requiring each patient have a checking account or credit card on file for balances less than \$50. If a balance is over \$50, our office will call before making any charges.**

**Most of the balances due because of Co-Insurances are typically between \$2.00 and \$20.00. If your card is charged, you will receive a copy of the statement and receipt in the mail for your records.**

**If you choose not to have a checking account or credit card on file, a Statement Fee of \$15.00 per statement will be charged for administrative fee.**

**Thank you in advance for your cooperation!!!**

**Sincerely,**

**Jennifer Aguiar  
Practice Administrator**

**RECURRING PAYMENT AUTHORIZATION**  
**(Insurance Patients Only)**

I authorize, Joseph W. Aguiar MD PA, to use the following payment option for account balances under \$50.00.

**Checking Account**

Type of Account (Circle One)

Checking

Savings

HSA

Account # \_\_\_\_\_ Routing# \_\_\_\_\_

Name on Account: \_\_\_\_\_ Bank Name: \_\_\_\_\_

**Credit Card/Debit Card/HSA Card**

Type of Card (Circle One)

Mastercard

Visa

American Express

Card # \_\_\_\_\_ EXP Date: \_\_\_\_\_ CVV: \_\_\_\_\_

Name on Card: \_\_\_\_\_

Please list Billing Address for payment method selected.

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Please send receipts to me via (Circle One)**

Home Address on File

Billing Address on File

Email

Email: \_\_\_\_\_

\_\_\_\_\_ I elect to not have a payment method on file and understand there is a \$15.00 fee for each statement mailed.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_