LAWRENCE M. KOPLIN, M.D., F.A.C.S.
AMERICAN BOARD OF PLASTIC SURGERY

PATIENT REGISTRATION FORM

Patient Name:_____ Date: _____/_____/_____
(LAST) (FIRST) (M.I.)

Address:_____City:_____State:_____ Zip:_____

Home Phone:(_____)_____ Cell Phone:(_____)_____ Work Phone:(_____)_____

Social Security #:_____-_____-_____ Date of Birth:_____/_____/_____ Age:_____ Sex: ☐ M ☐ F

E-mail:_____ Marital Status: S M D W Name of Spouse:_____

Occupation:_____ Employed By:_____

Employer Address: _____ City:_____ State:_____ Zip:_____

Emergency Contact:_____ Emergency Contact Phone:(_____)_____

Reason for Referral:_____

Referred By:_____

Responsible Party:_____ Relationship_____

Do you have medical insurance: ☐ Yes ☐ No Insurance Company Name:_____

Insured Name:_____ Insured DOB:____/_____/____

Insured ID#:_____-_____-_____ Insured Group #:_____

Insurance Company Phone:(_____)_____ Secondary Insurance Company:_____

♦ PAST MEDICAL HISTORY ♦

	Date	Procedure
Operations:		
Serious illnesses:		
Injuries:		

♦ PERTINENT PRE-OPERATIVE INFORMATION

- Have you ever had difficulties with Local Anesthesia?:_____ General Anesthesia?:_____
- Have you ever had any excessive bleeding with Tooth Extraction?_____ Cuts?_____ Childbirth:_____
- For what, if any, conditions are you now under treatment by a physician?_____
- _____
- List ANY allergies to medications:_____
- What medications are you presently taking regularly?_____
- _____
- _____
- Consumption of the Following: Alcohol:_____ Tobacco_____ Coffee_____

Have you ever had, or currently have, any of the following?

☐ Asthma	☐ Cancer	☐ Diabetes	☐ Emphysema
☐ Facial paralysis	☐ Heart Disease	☐ High blood pressure	☐ Kidney Stones
☐ Measles	☐ Mumps	☐ Pneumonia	☐ Rheumatic Fever
☐ Polio	☐ Scarlet Fever	☐ Tuberculosis	☐ Whooping Cough
☐ Visual Problems	☐ Easily Bruise or Bleed	☐ Urinary tract infections	
☐ Breast masses, cysts or tumors	☐ Poor healing or unsightly scarring	☐ Severe or frequent headaches	

FAMILY HISTORY

Any Significant Health Problems in your immediate Family Members?

- Mother _____
- Father _____
- Brother _____
- Sister _____
- _____
- _____

♦ PERMISSION FOR PHOTOGRAPHY

I hereby grant permission to Lawrence M. Koplin M.D. and his designated representatives to take and use clinical photographs of my initial consultation or office visit, subsequent office visits and consultations and all operations for the purposes of plastic and reconstructive surgery with the understanding that such photographs are for confidential, clinical record purposes and that all photographs shall remain the property of the doctor.

DATE_____/_____/_____ _____

Signature of patient

_____

Signature of patient or Legal guardian, if minor

♦ PERMISSION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize Lawrence M. Koplin, M.D. to release information regarding services rendered by him and allow a photocopy of my signature to used to file for payment by my medical insurance company

DATE_____/_____/_____ _____

Signature of patient

_____

Signature of patient or Legal guardian, if minor

♦ FINANCIAL RESPONSIBILITY AND PERMISSION FOR PAYMENT

I hereby authorize and direct payment check(s) for benefits due to me for services rendered by Lawrence M. Koplin, M.D. and Roxsan Surgery Center, L.L.C., to be made directly to Dr. Koplin. Regardless of my insurance benefits, if any, I understand and agree that ultimately I am financially responsible for any professional services rendered, including but not limited to any balance that may remain on my account after insurance payments. I understand Dr. Koplin is not a participating physician on my insurance plan. I understand Roxsan Surgery Center, L.L.C. is not a participating facility on my plan. I understand I need to refer to my insurance plan booklet for coverage of non-participating physicians and facilities for coverage information. If my insurance is billed for a portion of my services, I will be responsible for coinsurance, deductibles, and non-covered services and supplies. Should my account become delinquent, I understand that I am responsible for any and/or all legal fees, court costs and collection charges involved as a result of any collection activity.

DATE_____/_____/_____ _____

Signature of patient

_____

Signature of patient or Legal guardian, if minor

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM