

Craig Dufresne, M.D., F.A.C.S.
Aesthetic Plastic & Reconstructive Surgery

PATIENT REGISTRATION

Full Name of Patient: _____ Date of Birth: ____ _ Age: _____

Name of Spouse/Parent (if applicable): _____

Home Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Work Phone: (____) _____ Marital Status: ____ Sex: ____ SSN: _____

Emergency Contact: _____ Telephone: _____

Employer: _____

Primary Insurance:

Secondary Insurance (if applicable):

Ins. Co. Name: _____ Ins. Co. Name: _____

*** Please present your insurance card(s) and a photo I.D. at the front desk. If the patient is a minor or a dependent, please fill out the following information:**

Subscriber's Name: _____ Subscriber's Name: _____

Subscriber's Date of Birth: _____ Subscriber's Date of Birth: _____

Relationship to Patient: _____ Relationship to Patient: _____

Reason for Consultation: _____

Patient Referral: _____ Physician Referral: _____ Other: _____

I acknowledge that I am responsible for services rendered, not my insurance company. I agree to pay in full at the time of service. Any exception to service rendered that is billed, I authorize payment to be paid directly to the physician.

I hereby authorize you to release my medical information when appropriate (for medical and/or insurance purposes only). I also authorize you to request copies of my medical records from other physicians and/or medical facilities in conjunction with my care.

Signature: _____ Date: _____

A copy of the HIPAA Privacy Practice has been provided to me. I understand that it will be updated every year and will be made available to me upon request. _____

MEDICAL HISTORY

Full Name of Patient: _____ Today's Date: ____ _

Date of Birth: ____ _ Age: _____ Sex: _____ Height: _____ Weight: _____

Are you under the care of a physician? Yes No If so, please list name: _____

When were you last seen by your regular physician? _____

Have you ever had surgery? Yes No If yes, please explain: _____

Have you or any immediate family member had any problems with anesthesia? Yes No

If yes, please explain: _____

Please list your previous hospitalizations: _____

Are you taking any medications? Yes No If yes, please list: _____

Are you taking any non-prescription medications? (vitamins, supplements, herbs) Yes No If yes, please list: _____

Do you have any allergies? Yes No If yes, please name: _____

Do you have a latex allergy? Yes No

Do you take Aspirin regularly? Yes No

Do you smoke? Yes No If yes, how many packs per day? _____

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

Do you exercise regularly? Yes No

Are you pregnant? Yes No

Do you have a history of any of the following?:

- | | | | |
|------------------------------|--|------------------------|--|
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Liver Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hiatal Hernia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood clots in lungs or legs | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sleep Apnea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other Medical Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you answered "yes" to any of the above, please explain: _____

Do you now, or have you ever used recreational drugs? Yes No If so, when was the last time? _____

Have you ever taken any antidepressant or psych medications? Yes No If yes, please list medication and date taken: _____

Have you ever had a blood transfusion? Yes No If so, when? _____

How would you describe your present health? Excellent Good Fair

FINANCIAL POLICIES

As patients approach surgery, they frequently need information about the various payment options and have questions about their potential insurance benefits. We hope the following information will be helpful:

Insurance Coverage

- Cosmetic surgery is not covered by insurance.
- Dr. Dufresne is an Out-of-Network provider. We do not participate as an insurance provider for any company, including Tricare. As a courtesy, we will submit your claim(s) to your insurance company. Any insurance reimbursements we do receive will be reimbursed to you.
- Please discuss all arrangements regarding payment of your account with us.

Payment Options

- At the time of scheduling, a 50% deposit of the doctor's fee is required to reserve the operating room time. The balance is due three (3) weeks prior to the date of surgery, at the pre-op visit. Surgery revisions must be completed within twelve (12) months and are subject to a surgical charge.
- **Cash or check:** Personal check, cashier's check or cash.
- **Credit cards:** Visa, Master Card, American Express.
- **CareCredit:** We accept CareCredit financing. Restrictions may apply.

Cancellation Policy

- If you need to cancel your regular/follow-up appointment, please give our office a 24 hour notice otherwise you may be subject to a cancellation fee.
- If you have any questions or need assistance with financial matters, please phone our office at (703) 207-3065.
- I acknowledge that I am responsible for the services rendered, not my insurance company. I agree to pay in full at the time of service. Any exception to service rendered that is billed, I authorize payment to be made directly to Craig Dufresne & Associates, M.D.
- **Authorized signature** – I hereby authorize you to release my medical information when appropriate (for medical and insurance purposes only).

Signature: _____ Date: _____

WAIVER FOR MEDICAL SERVICES

I, _____, understand that I am choosing to see Dr. Dufresne outside of my insurance plan. By doing so, I understand that I am fully responsible for all medical billing incurred as the result of any visit to Craig Dufresne & Associates, M.D.

For patients currently enrolled in Medicare:

MEDICARE SERVICES

I, _____, understand that I am fully responsible for payment of any visit or procedure with Dr. Dufresne that is billed to Medicare and rejected as a non-covered service.

Signature: _____ Date: _____