NIKESH K. PATEL, MD
New Reflections Plastic Surgery
1001 WEST MAIN STREET - SUITE A - FREEHOLD, NJ 07728
(732) 354-3792
(Please Print)

Today's Date:	PCP:	Email:

PATIENT INFORMATION

Patient's last name: First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Phone no. May we call _____ Text____ ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Work phone no. May we call___ Text__ ( )

The web is becoming a key way patients learn about our practice. Do you participate in any of the following? (check all that apply)

☐ Yelp	☐ Facebook	☐ Twitter	☐ Realself	☐ Blogging: if yes, where can we see it? http://

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no: May we call_____ ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no: May we call___ ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance ☐

☐ Welfare *(Please provide coupon)* ☐ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize New Reflections Plastic Surgery or insurance company to release any information required to process my claims. I authorize New Reflections Plastic Surgery and its agents to be my representative regarding any claims or appeals that may be required for my treatment.

Patient/Guardian Signature Date

Nikesh K. Patel, MD
New Reflections Plastic Surgery
1001 WEST MAIN STREET, SUITE A
FREEHOLD, NJ 07728
(732) 354-3792

Please complete Medical History Form to the best of your ability

Name _____ Age _____ Height _____ Weight _____

Purpose of Consultation
_____

How did you hear about Dr. Patel?
_____

Please circle all of the following medical conditions that you have or have had in the past:

Bleeding tendency hepatitis diabetes blood transfusion glaucoma dry eyes lung disease TB asthma wheezing emphysema bronchitis irregular heartbeat chest pain heart disease heart attack stroke epilepsy heartburn intestinal ulcers or bleeding depression mental illness drug or alcohol addiction any other serious injury or illness

Please list any **medications or herbal products** that you take on a regular or occasional basis. If you can, please also include dosage and frequency:

_____

_____

Please circle any medications that you are currently taking: Birth control pills aspirin ibuprofen containing drugs diet pills diabetic medications steroids glaucoma drops asthma medications Lanoxin nitroglycerin Isordil Inderal other heart medications Lasix other diuretics high blood pressure medications Coumadin Plavix tranquilizers sleeping pills antidepressants other pills or shots

Do you have any **allergies** to medications? _____ If so, please list drug and reaction:
_____

_____

_____

Has anyone in your family or you ever suffered from diabetes, high blood pressure, breast cancer or odd reactions to anesthesia. Please list:
_____

_____

Smoking can complicate surgery:

Do you or have you ever smoked?_____ If so, how much and for how long?
_____

Please list all previous surgeries that you have had :
_____
_____

_____
_____

_____
_____

Patient Signature: _____ Date: _____

AUTHORIZATION FOR AND RELEASE OF MEDICAL PHOTOGRAPHS/SLIDES/ AND/OR VIDEOTAPES

INSTRUCTIONS

This is a consent document that has been prepared to help inform you concerning permission to take photographs, slides, and/or videotapes and to use these images for a purpose as defined within this consent document.

It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by your plastic surgeon.

INTRODUCTION

Medical photographs/slides and videotapes may be taken before, during, or after a surgical procedure or treatment. Consent is required to take such images.

Additionally, patients may consent to release these medical photography/slides, and videotapes for a stated purpose.

1. CONSENT TO TAKE PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize Nikesh K. Patel, M.D. and or his/her associates or licensees to take pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes. I additionally consent to photographs, slides, and/or videotapes of my interview.

I hereby grant permission for the use of any medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing, and /or certifying purposes by the American board of Plastic Surgery, Inc.

2. CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize Nikesh K. Patel, M.D. and or his/her associates or licensees to use pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes for professional medical purposes deemed appropriate including but not limited to showing these images on public or commercial television, electronic digital networks, for purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups.

_____I hereby grant permission for the use of my image and likeness in photography, video recordings, and digital images for use, demonstration, educational, and promotional purposes. This may include print media, television, or internet based platforms such as mobile and social networks and the internet/web. This may include but may not be limited to Facebook, Instagram, Snapchat, Messenger applications etc.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and /or my interview.

Patient Signature:.....

Date:……

Witness:.....

Nikesh K Patel, MD
New Reflections Plastic Surgery
1001 West Main Street, Suite A
Freehold, NJ 07728
(732) 345-3792

NOTICE OF PRIVACY POLICY

I certify that I have received and read the PRIVACY POLICY from Dr. Patel's office.

Signature _____

Printed Name _____

Date _____

NIKESH K. PATEL, MD
NEW REFLECTIONS PLASTIC SURGERY
1001 WEST MAIN STREET, SUITE A, FREEHOLD, NJ 07728
(732)354-3792

OFFICE NOTES

NAME: DOB:

DATE: