

MEDICAL HISTORY

Name _____ Date _____

Height _____ Weight _____ Allergies to medications _____

Do you Smoke? Yes No If yes, how much? _____ and for how long? _____

If female, are you pregnant? Yes No

Please list name and dosage of all medications you are now taking:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you had:

Heart disease _____	Tuberculosis _____	Cancer _____
Lung disease _____	Rheumatic fever _____	Bleeding Tendencies _____
Kidney disease _____	Serious infections _____	Hepatitis _____
Arthritis _____	Diabetes _____	H.I.V. or AIDS _____

Other medical conditions:

	Year	Hospital	Doctor
1) _____			
2) _____			
3) _____			
4) _____			
5) _____			
6) _____			
7) _____			
8) _____			

Geoffrey E. Leber, M.D., P.C.
Aesthetic & Reconstructive Plastic Surgery

RELEASE OF YOUR HEALTH INFORMATION

Who may receive information regarding your Protected Health Information? (Check all that apply)

Spouse Name and Birthdate: _____

Children Names and Birthdates: _____

Significant Other/Friend Name and Birthdate: _____

May we leave messages regarding appointments or other health information on your answering machine? yes no

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I have been presented with a copy of Dr. Geoffrey Leber's "*Notice of Privacy Practices*" policy, detailing how my information may be used and disclosed as permitted under Federal and State Law. I understand the contents of the Notice, and I place no additional restriction(s) concerning my personal medical information. This authorization may be revoked in writing by me at any time.

Date: _____ Signature: _____

AUTHORIZATION, ASSIGNMENT AND RELEASE

I acknowledge that the information supplied on this registration form is true and correct and that it has been furnished to this office with full understanding that I am liable for payment of all services rendered regardless of insurance coverage. If my account is referred to a collection agency, I agree to pay collection expenses including attorney's fees. Confidentiality rights shall be waived if collection becomes necessary. I hereby authorize and request that payments under my insurance plans be made directly to Geoffrey E. Leber, M.D. for any services furnished to me. I also authorize the release of any information required to process insurance claims, including any information relating to alcohol abuse, drug abuse, and/or AIDS/HIV.

Date: _____ Patient/Parent/Guardian Signature: _____