DARRICK E. ANTELL, M.D., P.C.

PATIENT NAME: _____
First Middle Last

BIRTHDATE: ____/____/____ AGE: _____ SS#: _____-_____-_____ SEX: M \ F (Circle one)
MM DD YYYY

ADDRESS: _____
Street Apt # City State Zip

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL: _____

MARITAL STATUS: ☐ Single ☐ Married to: _____ ☐ Other: _____

EMPLOYER AND EMERGENCY CONTACT

PATIENT'S EMPLOYER: _____ OCCUPATION: _____

WORK ADDRESS: _____
Street City State Zip

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

EMERGENCY CONTACT: HOME: _____ WORK: _____ CELL PHONE: _____

REFERRAL INFO AND AREAS OF INTEREST

HOW WERE YOU REFERRED TO DR. ANTELL: _____ HAVE YOU VIEWED HIS WEBSITE: Y/N

WHAT PROCEDURE ARE YOU INTERESTED IN TODAY? (Mark all that apply)

Facial Procedures

- ☐ Blepharoplasty (Eyelid Surgery)
- ☐ Brow or Forehead Lift
- ☐ Chin Augmentation
- ☐ Earlobe Repair
- ☐ Facial Liposuction (Neck, Jowls)
- ☐ Face or Neck Lift
- ☐ Otoplasty (Ear Pinning)
- ☐ Rhinoplasty (Nose Reshaping)

Breast Procedures

- ☐ Breast Augmentation
- ☐ Breast Reconstruction
- ☐ Breast Reduction
- ☐ Gynecomastia
- ☐ Implant Exchange
- ☐ Mastopexy (Breast Lift)
- ☐ Nipple Reduction or Inversion
- ☐ Skin Resurfacing (Peel, Dermabrasion)

Body Procedures

- ☐ Abdominoplasty (Tummy Tuck)
- ☐ Brachioplasty (Arm Lift)
- ☐ Liposuction
- ☐ Lipoma Removal

Non-Surgical Procedures

- ☐ Botox
- ☐ Chemical Peels
- ☐ Fine Line/Wrinkle Fillers

☐ Other Procedures not listed above: _____

I understand that office visits and procedures are payable on the day service is rendered.

Signature: _____ **Date:** _____

DARRICK E. ANTELL, M.D., P.C.

Confidential Record: Information contained here will not be released unless you have authorized us to do so.
Please answer ***ALL*** questions to the best of your knowledge.

PATIENT NAME: _____ REASON FOR VISIT: _____

AGE: _____ HEIGHT: _____ WEIGHT: _____ CURRENT PHYSICIAN(S): _____

HAVE YOU EVER HAD A PROCEDURE BY DR. ANTELL: YES/NO IF YES, WHICH PROCEDURE _____

LIST ALL PERVIOUS SURGERIES (PLEASE INCLUDE DATE):

LIST ANY SERIOUS ILLNESS AND/OR ACCIDENTS:

DO YOU HAVE OR HAD YOU HAD ANY OF THE FOLLOWING: IF YES, GIVE DATE OF ONSET/OCCURRENCE

Aids/ HIV	No Yes	Epilepsy/Seizures	No Yes	Ulcers	No Yes
Arthritis	No Yes	Facial Pain	No Yes	Pneumonia	No Yes
Asthma	No Yes	Fever Blisters	No Yes	Sinus Problems/Infections	No Yes
Bronchitis	No Yes	Goiter/Thyroid	No Yes	Stroke	No Yes
Cancer	No Yes	Hay Fever/Allergies	No Yes	Tonsillitis	No Yes
Depression	No Yes	Headaches/Migraines	No Yes	Tuberculosis	No Yes
Diabetes	No Yes	Heart Trouble	No Yes		
Dizziness/Vertigo	No Yes	Hepatitis	No Yes		
Ear Infection	No Yes	High Blood Pressure	No Yes		

DO YOU SMOKE: YES/NO IF YES, HOW OFTEN: _____ PACK(S)/DAY FOR HOW LONG: _____ YEARS

DO YOU DRINK ALCOHOL: YES NO IF YES, HOW MANY DRINKS: _____ HOW OFTEN: _____

DO YOU USE RECREATIONAL DRUGS: YES/NO IF YES, DESCRIBE _____
DO YOU HAVE BLEEDING/BRUISING PROBLEMS: YES/NO IF YES, DESCRIBE _____
HAVE YOU PREVIOUSLY HAD PROBLEMS SCARRING: YES/NO IF YES, DESCRIBE _____
HAVE YOU EVER HAD ANY PROBLEMS WITH ANESTHESIA: YES/NO IF YES, DESCRIBE _____

LIST ALL MEDICATIONS (INCLUDING DOSAGE AND FREQUENCY) YOU ARE PRESENTLY TAKING:

LIST ALL DRUG AND/OR LATEX ALLERGIES:

WOMEN ONLY:

ARE YOU CURRENTLY PREGNANT: YES/NO NUMBER OF CHILDREN: _____

The above information is accurate and complete to the best of my knowledge.

Signature: _____ Date: _____

Darrick E. Antell, M.D., P.C.

Patient Acknowledgement Form & Chaperone Policy

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgement. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy. (See Insert)

At any time, at the request of the patient, we are happy to provide you with a chaperone. Some patients would feel more comfortable having another person in the examination room, in addition to themselves and Dr. Darrick Antell. This may be a friend or family member, or a member of our staff. Your comfort is one of our primary concerns, and we value this. Simply address your request for a chaperone to Dr. Darrick Antell or anyone on our staff, and we will accommodate you.

Chaperone Requested: YES_____ NO_____ (Please initial one choice)

Choosing "Yes" means that you **REQUIRE** one of ***Dr. Antell's staff members*** to be present, along with Dr. Antell, during the entirety of your consultation.

Minors must always be accompanied by a parent or legal guardian when a physical examination is performed, or one of Dr. Darrick Antell's staff will be present at the examination. At the minor's request, and with the parent or legal guardian's agreement, the minor may be examined without the parent or legal guardian in the examination room.

On rare occasions, in an emergency, Dr. Darrick Antell may see you after hours in his office or at your home. At such time, no office staff is available to serve as a chaperone. Should such an occasion arise, Dr. Darrick Antell requires that you be accompanied by a family member or friend.

By signing this form you acknowledge that you have been informed of our use and disclosure of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our notice has been provided to you: that you understand the contents of our Notice, how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

_____ _____/_____/_____

Name Date

Darrick E. Antell, M.D.
(NYC Reconstructive Surgery, P.C.)

Insurance

We want to thank you for allowing us to provide your health care. We appreciate your trust in us, and we appreciate the opportunity to serve you. In order to better serve you, we try to contain the ever-rising cost of health care. In an effort to do so, we use the AAAA certified facility, Columbia East Side Ambulatory Surgery Facility, P.C. to perform surgery that would otherwise be much more costly if done in a hospital setting.

There will be a separate charge for Columbia East Side Ambulatory Surgery Facility that will be billed to your insurance company for reconstructive procedures or billed to you for cosmetic procedures.

Insurance may be applicable for some reconstructive and medically necessary procedures. Please indicate your coverage below.

Name of Insurance Company:_____

Policy and Group Number:_____ HMO/PPO (circle one)

Name of Policy Holder:_____ SS #:_____

****Please provide your insurance card to the receptionist****

Patient's Authorization to Release Medical Information and Claim Payment Authorization: I hereby authorize NYC Reconstructive Surgery, P.C. and Columbia East Side Ambulatory Surgery Facility to release any information, including medical records, regarding services rendered and allow a photocopy of my signature to be used to file for insurance. I hereby authorize Dr. Antell's practice to file appeals to my insurance provider regarding any claim submitted on my behalf.

I hereby authorize and direct payment check(s) for benefits due the doctor for services rendered by Dr. Antell's practice as well as benefits for the use of the accredited operating room facility to be made directly to the practice regardless of my insurance benefits, if any. I grant my power of attorney for his designated representative to pursue these benefits. I understand that I am financially responsible for the fees for services rendered.

Note:
The practice is defined as:

NYC Reconstructive Surgery, P.C.	(The professional fee)
Columbia East Side Ambulatory Surgery Facility, P.C.	(The facility fee)

I HAVE READ AND FULLY UNDERSTAND THE ABOVE INFORMATION.

_____ _____

Signature of Patient or Authorized Person if a Minor **Date**

I consent to my doctor and his staff communicating with me via regular mail at my address given above as well as by [ ] telephone [(_____)-_____-_____], and/or [ ] e-mail (_____)

SUBMIT