

**NORMAN LEAF, M.D., F.A.C.S.**  
PLASTIC AND RECONSTRUCTIVE SURGERY



## New Patient Forms

### Patient Forms

- Patient Information
- Health Information
- Insurance Information
- Patient Acknowledgement  
(Notice of Privacy Practices)

**NORMAN LEAF, M.D., F.A.C.S.**

PLASTIC AND RECONSTRUCTIVE SURGERY



Patient Information as of \_\_\_\_\_ (enter today's date)  
(Please Print Legibly & Fill In or Correct All Fields)

**Patient's Name**

\_\_\_\_\_ First Middle Last

Address \_\_\_\_\_  
Street & Apt # City State Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

E-mail \_\_\_\_\_

How may we communicate with you confidentially? (phone, email, Address etc)

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Gender  Female  Male

Marital Status  Single  Married  Domestic Partner  Other: \_\_\_\_\_

**Employer**

\_\_\_\_\_ Occupation \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext: \_\_\_\_\_

Address \_\_\_\_\_  
Street & Suite # City State Zip

**How did you hear about Dr. Leaf?**

(Mark all that apply)

TV News  TV Ad  Phone Book  Magazine  Newsletter  Seminar  Salon  Web  
 Friend/Relative: \_\_\_\_\_  Doctor: \_\_\_\_\_  Other: \_\_\_\_\_

**Emergency Contact**

\_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Other \_\_\_\_\_

**Primary Health Insurance Company**

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Ins. Phone \_\_\_\_\_

Referral Required?  No  Yes Copay?  No  Yes, \$ \_\_\_\_\_

Insured: Name \_\_\_\_\_ DOB \_\_\_\_\_ Employer \_\_\_\_\_

**Secondary Health Insurance Company**

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Ins. Phone \_\_\_\_\_

Referral Required?  No  Yes Copay?  No  Yes, \$ \_\_\_\_\_

Insured: Name \_\_\_\_\_ DOB \_\_\_\_\_ Employer \_\_\_\_\_

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Leaf to bill my insurance company for medically necessary services. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Leaf and myself.

**Signature**

\_\_\_\_\_ **Date** \_\_\_\_\_

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Health Information as of \_\_\_\_\_ (enter today's date)  
 (Please Print Legibly & Fill In or Correct All Fields)

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.

Name: \_\_\_\_\_ Reason for Visit: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Feet \_\_\_\_\_ Inches Weight: \_\_\_\_\_ Lbs.

Current Physician(s): \_\_\_\_\_

List all Surgeries (Hospitalization and the Date of Occurrence):

List any Serious Illnesses and/or Accidents:

Do you have or have you had any of the following: (circle for each, give date occurred if Yes)

Aids / HIV	No	Yes	Epilepsy / Seizures	No	Yes	Kidney Problems	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 / Migraine	No	Yes	Tuberculosis	No	Yes
Diabetics	No	Yes	Heart Trouble	No	Yes	Ulcers	No	Yes
Dizziness / Vertigo	No	Yes	Hepatitis	No	Yes			
Ear Infection	No	Yes	High Blood Pressure	No	Yes			

Do you smoke? No Yes If yes, how much? \_\_\_\_\_ Pack(s)/day How long? \_\_\_\_\_ Years

Do you drink alcohol? No Yes If yes, how much? \_\_\_\_\_ How often? \_\_\_\_\_

Do you use recreational drugs? No Yes If yes, describe: \_\_\_\_\_

Do you have bleeding or bruising problems? No Yes If yes, describe: \_\_\_\_\_

Do you have problems with scarring? No Yes If yes, describe: \_\_\_\_\_

Do you have any history of problems with anesthesia? No Yes If yes, describe: \_\_\_\_\_

List the name of all medications you are presently taking or have taken within the last month. Please include the name of the drug, dosage and frequency.

List ALL drug and/or latex allergies.

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

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**Insurance Information & Authorization**  
(Please Print Legibly Sign)

Patient's Name \_\_\_\_\_  
First Middle Last

Primary Insurance Company \_\_\_\_\_

Policyholder's Information:

Name \_\_\_\_\_ Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Employer \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Copay Amount \$ \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_

Policyholder's Information:

Name \_\_\_\_\_ Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Employer \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Copay Amount \$ \_\_\_\_\_

Is this visit due to any type of accident?  No  Yes: Date of Accident \_\_\_\_\_

Type of Accident  Auto: State? \_\_\_\_\_  Work Related  Other: \_\_\_\_\_

**All Insurance Patients – Signature on File**

I request that payment of authorized benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the above listed insurance companies and their agents any information needed to determine these benefits payable for related services.

Beneficiary Signature \_\_\_\_\_ Date \_\_\_\_\_

**Medicare Patients Only – Medicare Signature on File**

I request that payment of authorized Medicare benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature \_\_\_\_\_ Date \_\_\_\_\_

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## Notice of Privacy Practices - Patient Acknowledgement Form

This is a general summary notice of our privacy practices and describes, in brief, how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you.

### Our Legal Duty

Law Requires Us to:

1. Keep your medical information private.
2. Provide or post a copy of the full notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

### Your Individual Rights

1. Look or get copies of certain parts of your medical information. You must make your request in writing (there may be a service charge for copies of medical records, please allow at least 5-7 business days for copies to be prepared.)
2. Receive a list of all times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement.
4. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
5. If you have received this notice electronically, and you wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to us.

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

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Date

Full Name