GEORGE ORLOFF, M.D.

PLASTIC & RECONSTRUCTIVE SURGERY

Date_____ Home Phone_____ Cell#_____

Patient_____
Last Name First Name Initial

Responsible Party (if a minor)_____

Street Address_____ E-mail address_____

City_____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐S ☐M ☐W ☐D
(Marital Status)

Patient Employed By_____

Business Address_____

Occupation_____ Business Phone_____

Spouse (or responsible party) Name_____Birthdate_____

Business Name and Address_____

Occupation_____Business Phone_____

Patient Social Security #_____ CDL #_____

Do you have Medical Insurance? ☐ No ☐ Yes If yes,

Name of Primary Insurer_____

Subscriber #_____ Group #_____

Name of Secondary Insurer (if any)_____

Subscriber #_____ Group #_____

In case of emergency, who should be notified?_____ Phone_____

Referred by_____

ASSIGNMENT AND RELEASE

I hereby authorize examination and whatever services deemed necessary by George Orloff, M.D. I, the undersigned, assign directly to Dr. George Orloff, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Patient/Insured/Guardian Date

Medical History

Please specifically give the reason for your visit:_____

Please list all drug-related allergies or intolerances:_____

Are you under a doctor's care?_____ Name:_____

Phone:_____

Do we have permission to contact your doctor or allergist? Yes No

Do you have a history of (circle correct answer):

Heart trouble	Yes No	Nasal allergy	Yes No	Do you smoke cigarettes	Yes No
Diabetes	Yes No	Post-nasal discharge	Yes No	Dry or itchy eyes	Yes No
Ulcer	Yes No	Sinus infections	Yes No	Burning of the eyes	Yes No
Anemia	Yes No	Nose bleeds	Yes No	Do you drink alcohol?	Yes No
Asthma	Yes No	Headaches	Yes No	0-1 drinks per day	
Pulmonary trouble	Yes No	Hepatitis	Yes No	2-3 drinks per day	
High blood pressure	Yes No	Difficulty breathing	Yes No	4 + drinks per day	
Positive HIV/AIDS	Yes No	through nose		**Height** _____	**Weight**_____

List all medications you are currently taking (including over the counter medicines, aspirin containing medicines, birth control pills or Vitamin E), along with the dosage: _____

List all previous operations or major illness you have had, along with approximate dates:_____

Have you had any exposure to HIV through prior sexual history, surgery, transfusions of IV drug use?	Yes No
Have you had reaction to anesthetics?	Yes No
Do you have history of increased bleeding tendency?	Yes No
Have you ever had a blood transfusion?	Yes No
Have you ever been under the care of a psychiatrist or had a nervous breakdown?	Yes No
Do you wear glasses?	Yes No
Do you wear contacts?	Yes No
Do you have history of bad scarring?	Yes No

If yes, where?_____

List any other important information _____

_____

I consent to photographic documentation of my treatment. These images can be used for medical, scientific, educational, or commercial purposes and are the property of Dr. Orloff.

This information is correct and complete to the best of my knowledge:

_____ _____

Signature of patient Date

INSURANCE COVERAGE POLICY

The following financial policy applies to all patients who have insurance coverage. Please carefully read and sign this agreement providing you agree with it. Let our finance staff know if you have any questions.

1. We will be happy to bill your insurance company for your care providing you give us all the information we need. Even though you have insurance coverage, please remember it is your personal bill.

2. You will need to pay your portion of the charge as you go or in advance. This includes the annual deductible, co-payment and charges your insurance company does not pay. Our office policy does not allow us to extend credit.

3. We will need to verify your insurance benefits by contacting the insurance company.

Please Note: Until we have verified your coverage, you will be responsible for paying for your own care at each visit, including the first visit. After we verify your coverage, we will credit the amount you have paid to your portion of the bill.

4. We will bill your insurance company every two weeks. Payment is expected within 60 days. We will automatically transfer and bill you for any payments not received from your insurance company after 60 days. You need to pay us in full at that time. Any amounts you personally owe that are 30 days late will receive a service charge of 1½% per month.

5. Occasionally, an insurance company will send a payment to a patient. If this occurs, bring us the check and the attached stub. The information on the stub is very important.

6. Your insurance company may request additional information from you. Please send the information to them right away. They will not pay your claim until they receive the information.

7. If you suspend or terminate your care against the advice of your doctor, all outstanding charges that have not been paid by you or your insurance company will become immediately due and payable by you personally before you leave.

By signing below, you agree to follow this policy.

SIGNED:

_____ _____

Patient Signature Date

_____

Print Name

_____ _____

Staff Member Date

Effective Date: April 14, 2003

GEORGE ORLOFF, M.D., INC.

Notification and Acknowledgement of Notice of Privacy Practices Regarding Protected Health Information

Our Notice of Privacy Practices provides detailed information about how we may use and disclose protected health information about you. As a patient, you have a right to a copy of that Notice. You may obtain a copy for the Notice from our registration desk or by mail.

George Orloff M.D., Inc.
2301 W. Alameda Ave.
Burbank, CA 91506

We reserve the right to change the Notice, and if we do, you may obtain a copy of the revised Notice from the same location as noted above.

Please acknowledge your receipt of this notification by signing below. Thank you.

Signature: _____