PATIENT REGISTRATION

DATE_____FAMILY/REFERRING DR._____

PATIENT NAME_____BIRTH DATE_____/_____/_____

ADDRESS_____CITY_____ STATE_____ ZIP_____

EMAIL_____ DRIVERS LICENSE_____

PATIENT S.S. #_____PHONE_____AGE_____

SEX M □ F □ MARITAL STATUS S □ M □ W □ D□ Cell Phone_____

PATIENT EMPLOYER &ADDRESS_____

EMPLOYER PHONE_____

REASON FOR VISIT_____ IS VISIT DUE TO AN INJURY □YES □NO

REFERRED BY WHOM_____

SPOUSE OR NEAREST RELATIVE_____PHONE_____

ADDRESS_____RELATIONSHIP_____

RESPONSIBLE PERSON NAME_____S.S. #_____

ADDRESS_____

PHONE (H)_____(W)_____RELATIONSHIP_____

EMPLOYER & ADDRESS_____

INSURANCE INFORMATION

PRIMARY CARRIER_____ Card Holder Name_____

ADDRESS_____ Card Holder Date of Birth_____

I D #_____GROUP # _____PLAN_____

SECONDARY CARRIER_____ Card Holder Name_____

ADDRESS_____ Card Holder Date of Birth_____

I D #_____GROUP #_____PLAN_____

I HEREBY AUTHORIZE DR. PECK, AND WHERE APPLICABLE, ESSEX SURGICAL, LLC, AND /OR THE ANESTHESIOLOGIST TO RELEASE ANY INFORMATION REGARDING SERVICES RENDERED AND ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO FILE INSURANCE. I ALSO AUTHORIZE AND DIRECT PAYMENT FOR BENEFITS DUE ME FOR THE SERVICES RENDERED BY THE PREVIOUSLY NAMED PARTIES TO BE MADE TO HIM/THEM REGARDLESS OF MY INSURANCE BENEFITS. PHOTOCOPIES OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR THE FEES FOR SERVICES RENDERED. OUTSIDE LABORATORY FEES ARE THE PATIENTS RESPONSIBILITY.
WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS. THIS MAY INCLUDE FAXING INFORMATION FOR HEALTHCARE PURPOSES AND BILLING, AS WELL AS LEAVING MESSAGES FOR APPOINTMENTS AND HEALTH CARE (PRE/POST OPERATIVE CALLS ARE INCLUDED).

NAME_____DATE_____

PATIENT SIGNATURE/RESPONSIBLE PERSON

ALLERGIES, ILLNESSES AND MEDICAL PROBLEMS

YOUR NAME_____**DATE**_____

	YES	NO	EFFECT		YES	NO	EFFECT
PENICILLIN	☐	☐	_____	**TAPE**	☐	☐	_____
OTHER MEDICATION	☐	☐	_____	**HAY FEVER**	☐	☐	_____
_____	☐	☐	_____	**FOOD**	☐	☐	_____
IODINE	☐	☐	_____	**SHELL FOOD**	☐	☐	_____
CONTACT ALLERGY	☐	☐	_____	**SHELL FOOD**	☐	☐	_____

EXPLAIN ALLERGIC EFFECTS: _____

DATE OF LAST TETANUS SHOT: _____

ILLNESS & MEDICAL PROBLEMS:

YES	NO		YES	NO	
☐	☐	**HIGH BLOOD PRESSURE**	☐	☐	**BRONCHITIS**
☐	☐	**HEART ATTACK**	☐	☐	**EMPHYSEMA**
☐	☐	**HEART MURMUR**	☐	☐	**PNEUMONIA**
☐	☐	**OTHER HEART PROBLEMS**	☐	☐	**TUBERCULOSIS**
☐	☐	**DIABETES**	☐	☐	**ANESTHESIA PROBLEMS**
☐	☐	**DIZZY SPELLS**	☐	☐	**STOMACH ULCER**
☐	☐	**GLAUCOMA**	☐	☐	**COLITIS**
☐	☐	**OTHER EYE TROUBLE**	☐	☐	**DIVERTICULOSIS**
☐	☐	**EAR TROUBLE**	☐	☐	**HEPATITIS**
☐	☐	**SINUS TROUBLE**	☐	☐	**MONONUCLEOSIS**
☐	☐	**DEAF OR HEARING IMP.**	☐	☐	**GALL BLADDER TROUBLE**
☐	☐	**NOSE BLEEDS**	☐	☐	**STROKE**
☐	☐	**NOSE OBSTRUCTION**	☐	☐	**SLEEP APNEA/DISORDERS**
☐	☐	**SWELLING IN NECK**	☐	☐	**CONVULSIONS/SEIZURES**
☐	☐	**ASTHMA**	☐	☐	**THYROID PROBLEMS**
☐	☐	**HEALING PROBLEMS**	☐	☐	**KIDNEY / BLADDER PROBLEMS**
☐	☐	**HERNIAS**	☐	☐	**VARICOSE VEINS**
☐	☐	**LOW BLOOD PRESSURE**	☐	☐	**BLEED EASILY**
☐	☐	**ARTHRITIS**	☐	☐	**EYE PROBLEMS**
☐	☐	**BRUISE EASILY**	☐	☐	**PARALYSIS**
☐	☐	**BLEEDING DISORDER**	☐	☐	**CANCER:**
☐	☐	**ANKLE SWELL**	**YEAR / TYPE** _____		
☐	☐	**MENTAL / NEUROLOGICAL CONDITION:** _____	☐	☐	**LUNG PROBLEMS:** _____
☐	☐	**HAVE YOU HAD A MOLE SCREENING? DATE:**_____			
☐	☐	**DO YOU HAVE ANY MOLES / BEAUTY MARKS WHICH ARE IREGULAR, MULTI-COLORED, OR HAVE CHANGED?**			

WOMEN ONLY

☐	☐	**TENDER BREASTS**	☐	☐	**LUMPS OR OR RECENT SIZE/COLOR CHANGE**
☐	☐	**FIRBROCYSTIC DISEASE**	**PREVIOUS MAMMOGRAM YEAR:**_____		
☐	☐	**MENSTRUAL PROBLEM**	**LAST MENSTRAL PERIOD:** _____		
☐	☐	**WERE YOUR CHILDREN BREAST FED**	**NUMBER OF CHILDREN:** _____		
☐	☐	**DO YOU PLAN TO HAVE CHILDREN?**			

HAVE ANY OF THE ABOVE CONDITIONS APPEARED IN YOUR IMMEDIATE FAMILY? IF SO, SPECEFY:

MEDICAL HISTORY

YOUR NAME _____WEIGHT_____HEIGHT _____

SURGERY (OPERATIONS):

1. _____
2. _____
3. _____
4. _____

ADMISSIONS TO HOSPITALS:

1. _____
2.
3. _____
4.
5. _____

MEDICATIONS (ANY DRUG OR MEDICATION) YOU TAKE NOW:

1. _____
2. _____
3. _____
4. _____

CONSUMPTION OF THE FOLLOWING:

Aspirin_____ Amount Daily _____ Amount Weekly_____
Alcohol _____ Amount Daily _____ Amount Weekly _____
Tobacco _____ Amount Daily _____ Amount Weekly _____

BLEEDING PROBLEMS: (WITH CUTS? TOOTH EXTRACTIONS? PREGNANCY? SURGERY?)
EXPLAIN:

DIFFICULTIES WITH LOCAL OR GENERAL ANESTHESIA:
EXPLAIN:

FAMILY HISTORY OR CONDITIONS UNDER TREATMENT BY A PHYSICIAN:
EXPLAIN:

FAMILY HISTORY: ANY FAMILY HISTORY OF MEDICAL PROBLEMS OR ILLNESS?
Mother_____ Father _____
_____ _____
Sister _____ Brother _____
_____ _____

PECK CENTER, INC./ESSEX SURGICAL, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse to sign this acknowledgement)

I, _____have received a copy of this office's Notice of Privacy Practices/Patient Rights in advance of my date of servicc.

_____

Please Print Name

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Privacy Practices, but acknowledgement could not be obtained because,

□ Individual refused to sign

□ Communications barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other (please specify)

_____

_____

_____

THE PECK CENTER, INC./ESSEX SURGICAL, LLC

PHOTOGRAPHIC RELEASE AND CONSENT

I understand and accept that I may be recognized from my likeness or case history. Nevertheless, I authorize my plastic surgeon to use my photographs, videotapes, and/or case information in the following, educational, scientific, and/or commercial settings that I have checked:

- ❑ **Lectures and multi-media presentations for an audience of medical professionals but where members of the press may be present.**
- ❑ **Medical, surgical, and scientific journal articles.**
- ❑ **My surgeon's office patient education materials; my surgeon's file of pre- and post-operative patient photographs available to my prospective patients for viewing in my office.**
- ❑ **Newspaper and magazine articles in which my surgeon participates; television programs in which my surgeon participates; my surgeon's personal website or web page; lectures and multi-media presentations given by my surgeon for the general public.**

Date: _____ **Date: _____**

_____ **_____**

Patient/Guardian Signature **Witness Signature**

_____ **_____**

Print Name **Print Name**

RICHARD E. PECK, MD/ESSEX SURGICAL, LLC
776 Northfield Avenue
West Orange, New Jersey 07052
Phone: 973-324-2300
Fax: 973-324-2300

PATIENT NAME: _____

I irrevocably assign to **Richard Peck, M.D./Essex Surgical, LLC**, all my rights and benefits under my insurance contract for payment of services rendered to me by **Richard Peck, M.D./Essex Surgical, LLC**. I irrevocably authorize **Richard Peck, M.D./Essex Surgical, LLC** to file insurance claims on my behalf for services rendered to me.

Richard Peck, M.D./Essex Surgical, LLC, has made me aware that all claims will be submitted to my insurance carrier if provided. Any Co-Pay, Co-Insurance and deductible will be my responsibility. All payments are to be directed to**, Richard Peck M.D./Essex Surgical, LLC**. There will be three attempts by**, Richard Peck, M.D./Essex Surgical, LLC**, to collect any debt. If **Richard Peck, M.D./Essex Surgical, LLC,** is unsuccessful in collecting your debt, it will be handed over for collections and/or suit. I understand that it is my responsibility to inform **Richard Peck, M.D./Essex Surgical, LLC,** of any insurance change to my current policy or change in insurance company, and if I do not do so, I will be fully responsible for all bills incurred related to my medical consultations, procedures and/or treatments.

This assignment of Benefits has been explained to my full satisfaction, and I understand its nature and effect. I hereby authorize photocopies of this form to be valid as the original.

Patient's Signature: _____ Date:_____

Witness: _____

THE PECK CENTER, INC.
ASSIGNMENT OF BENEFITS AND INSURANCE AUTHORIZATION

Patient Name_____ Claim # _____

I hereby authorize **DR. PECK/PECK CENTER, INC.,** to furnish information to insurance carriers concerning my illness and treatments. I hereby assign all payments, for medical services rendered to myself or my dependants, to the facility/ physicians. I understand that I am responsible for any amount not covered by my insurance. I UNDERSTAND THAT MY INSURANCE COMPANY HAS STATED MY COVERAGE HAS BEEN TERMINATED AND THAT I AM PERSONALLY RESPONSIBLE FOR ANY MEDICAL AND/OR FACILITY FEES CONCERNING MY ILLNESS AND TREATMENTS..

I am assigning all my rights unconditionally to t **DR. PECK/PECK CENTER, INC.,** to pursue any medical bills, relating to treatment or care by this office in addition to the above.

X_____
Patient or Responsible Party's Signature

No FAULT, VICTIMS OF CRIMES AND/OR WORKERS COMPENSATION PATIENTS

I hereby authorize the release of my medical chart, bills and/or any other information related to my treatment, to my attorney:_____. I further authorize **DR. PECK/PECK CENTER, INC.,** to pursue payment of my bills.

I understand that all medical bills will be submitted to the responsible insurance carrier and will ***only*** be submitted to my medical insurance carrier in the event that payment is denied and/or there is a remaining balance, for which I am responsible.

I understand that I am directly and fully responsible for all medical bills submitted by you for services rendered to myself or my dependants and that this agreement is made solely for your additional protection and in consideration of your awaiting payment. I further understand that your attorney, if needed, will arbitrate my bills for payment.

X_____
Patient or Responsible Party's Signature

ATTORNEY INFORMATION

Attorney Name:_____ Attorney Phone#:_____

Addresss:_____City_____State_____Zip_____