WELCOME TO THE PRACTICE

Please fill out these forms completely.

❑ **Mr.** ❑ **Mrs.** ❑ **Ms.** ❑ **Dr.** ❑ _____

LEGAL NAME:_____
First Middle Last

MAILING ADDRESS:_____
Street Apt #

_____
City State Zip

AGE:_____ **DATE OF BIRTH:** _____-
month/day/year

HOME PHONE (_____)_____ **WORK PHONE** (____)_____

MOBILE PHONE (_____)_____

EMAIL:_____ *please read attached consent form*
(if under 18, provide parent email address)

EMERGENCY CONTACT:_____**RELATIONSHIP:**_____

EMERGENCY CONTACT PHONE (_____)_____or (_____)_____

IF UNDER 18 YEARS OLD: PARENT/GUARDIAN NAME(S)_____

EMPLOYER:_____

WORK ADDRESS:_____
Street City State Zip

Consent for Disclosure to Family Members or Personal Representative:

I have agreed to let certain individuals participate in discussion and decisions related to my medical care. Therefore, I hereby give my permission to David Rosenberg, M.D., PLLC, David Rosenberg, M.D, Jessica Lattman, M.D., PLLC, Jessica Lattman M.D, Benjamin Paul, M.D., Medical Hair Restoration, PLLC, & Manhattan Facial Surgery Suites, PLLC, employees, agents, and staff to disclose my personal medical and financial information to the following individual(s). This includes discussion of surgical procedures, account information, making of appointments, prescription concerns, pre-op and post-op care, etc.

Name:_____ Relationship:_____ Phone:(_____) _____

Name:_____ Relationship:_____ Phone:(_____) _____

Cosmetic procedures are not covered by insurance. For reconstructive procedures, the doctors are out-of-network with all insurance carriers, however we will be happy to provide an itemized bill that you can submit to your out-of-network benefits for possible reimbursement.

Communication with the office: For urgent matters please call the office at 212-832-8595. Our phones are staffed 24 hours a day, 7 days a week. During hours that the office is closed, an on-call doctor will return your phone call. If you do not receive a phone call back within one hour please call again.
Email communication is not checked on weekends or after hours. For routine matters after hours, emails and phone messages will be answered on the next business day.

SIGNATURE:_____ **DATE:**_____

NAME:_____ **DATE:**_____

Reason for today's visit:_____

Height:_____ **Weight:**_____ **Date of Birth:**_____ **Age:**_____

Have you ever suffered from?

	Yes	No
Heart Disease	_____	_____
High Blood Pressure	_____	_____
Heart Attack	_____	_____
Emphysema	_____	_____
Asthma	_____	_____
Blood Disease	_____	_____
Kidney Disease	_____	_____
Glaucoma	_____	_____
Dry Eyes	_____	_____
Facial Trauma	_____	_____
Diabetes	_____	_____
Hepatitis/HIV	_____	_____
Cancer	_____	_____
Anemia	_____	_____
Easy Bruising	_____	_____
Depression	_____	_____
Eating Disorder	_____	_____
Sleep Apnea	_____	_____
Cold Sore(s)	_____	_____
Lung Disease	_____	_____
Clotting Disorder	_____	_____
Malignant Hypothermia	_____	_____

List past & current medical ad eye problems not mentioned above:

_____

_____

Do you take?	**Yes**	**No**
Aspirin	_____	_____
Coumadin	_____	_____
Lovenox	_____	_____
Vitamin E	_____	_____
Ginko	_____	_____
St John's Wort	_____	_____

What medications do you use?

_____

_____

_____

_____

_____

_____

What medications/food are you <u>ALLERGIC</u> to?

_____

_____

_____

Do you have a bleeding abnormality?

_____

Family medical history, please include eye conditions?

_____

_____

Have you been hospitalized? Yes____ No____
Please Describe:

_____

_____

Ever had cosmetic surgery? Yes____No____
Please Describe:

_____

_____

Ever had any other surgery? Yes____No___
Please Describe:

_____

_____

Ever had any issues with anesthesia? Yes____No___
Please Describe:

_____

_____

Do you currently have any of the following habits?

	Yes	**No**	
Smoking	_____	_____	
Frequency			_____
Alcohol	_____	_____	
Frequency			_____
Recreational Drugs	_____	_____	
Frequency			_____

Have any caps, crowns, bridges or loose teeth?

_____

Are you currently undergoing dental work?

_____

Have you ever taken/had?	**Yes**	**No**	**When?**
Fen Fen	_____	_____	_____
Accutaine	_____	_____	_____
Radiesse Injected In Face	_____	_____	_____

How did you hear of our office?

_____

_____

Internist Name/#: _____

_____

Cardiologist Name:_____

_____

Dermatologist Name:_____

_____

Ophthalmologist/Optometrist Name:_____

_____

PHARMACY NAME/#:_____

_____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby give my consent for The Office of Dr. David Rosenberg, The Office of Dr. Jessica Lattman and The Office of Dr. Benjamin Paul to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment, and Healthcare Operations (TPO). (The offices of Dr. David Rosenberg, Dr. Jessica Lattman and Dr. Benjamin Paul Notice of Privacy Practices provide a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Office of Dr. David Rosenberg, The Office of Dr. Jessica Lattman and The Office of Dr. Benjamin Paul reserve the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to The Office of Dr. David Rosenberg, The Office of Dr. Jessica Lattman or The Office of Dr. Benjamin Paul at 115 E. 61st Street, New York, NY 10065 & 225 E. 64th Street, New York NY 10065.

With this consent, The Office of Dr. David Rosenberg, The Office of Dr. Jessica Lattman and The Office of Dr. Benjamin Paul may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care.

With this consent, The Office of Dr. David Rosenberg, The Office of Dr. Jessica Lattman and The Office of Dr. Benjamin Paul may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, The Office of Dr. David Rosenberg, The Office of Dr. Jessica Lattman and The Office of Dr. Benjamin Paul may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that The Office of Dr. David Rosenberg, The Office of Dr. Jessica Lattman and The Office of Dr. Benjamin Paul restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to The Office of Dr. David Rosenberg, The Office of Dr. Jessica Lattman and The Office of Dr. Benjamin Paul use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it; The Office of Dr. David Rosenberg, The Office of Dr. Jessica Lattman and The Office of Dr. Benjamin Paul may decline to provide treatment to me.

_____ **DATE OF BIRTH:**_____

PATIENT (PLEASE PRINT)

_____ **TODAY'S DATE:** _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

EMAIL & TEXT CONSENT

"Our Office" shall be understood to mean David Rosenberg, M.D., David Rosenberg, M.D., PLLC, Jessica Lattman, M.D., Jessica Lattman M.D., PLLC, Benjamin Paul, M.D., Medical Hair Restoration, PLLC, Manhattan Facial Surgery Suites, PLLC, and it's physicians, employees, staff, and agents.

Email & Text Disclaimer

"Our Office" will use reasonable means to protect the privacy of your health information sent by email & text. However, because of the risks outlined below, "Our Office" cannot guarantee that email & text communications will be confidential. Additionally, "Our Office" will not be liable in the event that you or anyone else inappropriately uses your email or device that includes email or text. "Our Office" will not be liable for improper disclosure of your health information that is not caused by "Our Office's" intentional misconduct.

Email & Text Risks and Your Responsibility

At the discretion of "Our Office" and upon your agreement to the terms outlined within this consent form, you may use email, text, texts that includes text apps, to communicate with "Our Office." These emails & texts may contain your personal health information. If you decide to use email & text to communicate with "Our Office," you should be aware of the following risks and/or your responsibilities.

- As the Internet & Devices are not secure or private, unauthorized people may be able to read, intercept, and/or possibly modify email & text those sent from you or those that are sent by "Our Office."
- You must protect your email account, password, and computer against access by unauthorized people, as well as any device that includes email & text.
- Since email can be used to spread viruses, some which cause email messages to be sent to people who you do not intend to send email messages to, you should install and maintain virus protection software on your computer.
- As your employer may claim ownership of, or the right to access, the email account or device issued to you, you should avoid using an employer issued email account & employer issued device to communicate with "Our Office."

Conditions for the Use of Email & Text

By consenting to the use of email & text with "Our Office," you agree that:

- Although "Our Office" will try to read and respond promptly to your email & text, "Our Office" may not read your email & text immediately. Therefore, you should not use email or text to communicate with "Our Office" if there is an emergency or where you require an answer in a short period of time.
- If your email or text requires or asks for a response, and you have not received a response within a reasonable time period, it is your responsibility to follow up directly with the intended recipient.
- "Our Office" may forward your email or text as appropriate for diagnosis, treatment, reimbursement, and other related reasons. As such, other employees or agents of "Our Office," other than the recipient, may have access to email & text that you send. Such access will only be to such persons who have a right to access your email & text to provide services to you. Otherwise, "Our Office" will not otherwise forward email or text without your prior written consent, except as authorized or required by law.
- "Our Office" reserves the right to save your email & text and include your information contained within your email or text in your medical record.
- It is the patient's responsibility to follow up and/or schedule an appointment if warranted or recommended by "Our Office."
- You should carefully consider the risk of using email or text for the communication of sensitive medical information, such as, but not limited to, information regarding surgeries/procedures you are completing to undergo, or have undergone, personal health questions and information.
- You should carefully word your email & text so the information provided clearly, yet briefly, describes the information you intend to convey. You should avoid writing long email & text.
- You are responsible for correcting any unclear or incorrect information.
- Email & text may not be the only form of communication that "Our Office" will use to communicate with you. "Our Office" may decide that it is not in your best interest to continue to communicate with you by email.&/or text. In such case, "Our Office" will notify that it no longer intends to communicate with you by email &/or text.

Email & Text Instructions:

- You shall immediately inform individuals with whom you communicate with at "Our Office" of changes in your email & text address.
- You shall send email & text only to such "Our Office" email & text addresses as instructed.
- You shall put your name and such other information as is necessary for "Our Office" to identify you in the body of the email & text.
- Should you wish to discontinue communication via email &/or text you will need to do so in writing.

You consent to communicate by email & text by sending an email & text to all of the email & text addresses that you had previously communicated to.

I,_____, agree to the above conditions and instructions and consent to send
(Print Name)
and receive email & text from "Our Office." (Check if you do <u>not</u> consent to: □ Email. □ Text) I understand in order to revoke this consent I need to do in writing.

SIGNATURE:_____ **DATE:**_____