



**YOASH R. ENZER, MD, FACS**  
*Cosmetic, Laser, and Oculofacial Plastic Surgery*  
120 Dudley Street, Suite 104 | Providence, RI 02905  
(401) 274-4464 | [www.doctorenzer.com](http://www.doctorenzer.com)

## *Medical Patient Registration Form*

### **PATIENT INFORMATION**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Mobile Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Marital Status: \_\_\_\_\_

### **PERSONAL PHYSICIANS**

**Referring Doctor:** \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
**Eye Doctor:** \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
**Medical Doctor:** \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_

### **PHARMACY INFORMATION**

Name, Address: \_\_\_\_\_  
City, State: \_\_\_\_\_  
Phone #: \_\_\_\_\_

### **EMPLOYMENT INFORMATION**

Occupation: \_\_\_\_\_  
Spouse's Occupation: \_\_\_\_\_

### **HEALTH INSURANCE INFORMATION**

**Primary Insurance:** \_\_\_\_\_  
Member ID: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
**Secondary Insurance:** \_\_\_\_\_  
Member ID: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

### **WORKER'S COMP/PERSONAL INJURY**

Date of Injury: \_\_\_\_\_  
**Work related injury?** Yes No  
Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Worker's Comp. Company: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Worker's Comp Contact: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
**Personal injury claim?** Yes No  
Attorney's name: \_\_\_\_\_  
Phone #: \_\_\_\_\_

### **POWER-OF-ATTORNEY**

Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Phone #: \_\_\_\_\_

### **EMERGENCY CONTACT**

Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Phone #: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

### PERSONAL & FAMILY MEDICAL HISTORY

Place a check if you or a family member have been treated for:

|                              | You                      | Family                   |
|------------------------------|--------------------------|--------------------------|
| Diabetes                     | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure          | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid problems             | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart attack/irregular beats | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema/asthma             | <input type="checkbox"/> | <input type="checkbox"/> |
| Poor clotting/bruise easily  | <input type="checkbox"/> | <input type="checkbox"/> |
| Poor circulation             | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye problems                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Other significant condition  | <input type="checkbox"/> | <input type="checkbox"/> |

Please elaborate below:

### HAVE YOU EVER BEEN DIAGNOSED WITH:

|   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| Hepatitis?  | <input type="checkbox"/> | <input type="checkbox"/> |
| HIV?  | <input type="checkbox"/> | <input type="checkbox"/> |
| MRSA? ( <i>methicillin resistant Staphylococcus aureus</i> )<br>If so, when? _____                          | <input type="checkbox"/> | <input type="checkbox"/> |
| VRE? ( <i>Vancomycin resistant Enterococcus</i> )<br>If so, when? _____                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been in the hospital or any other overnight facility in the last six months?<br>If so, when? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep apnea?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you use a machine to breathe at night?   | <input type="checkbox"/> | <input type="checkbox"/> |

### MEDICATIONS

List all your current prescription medications, including dosages (use the back of the page if necessary):

List all of your herbal and over-the-counter medications including dosages (use the back of the page if necessary):

|   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| Do you take Aspirin?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you take non-steroidal anti-inflammatory medication (Advil, Aleve, Motrin, ibuprofen, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> |

### ALLERGIES

|   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| Have you or a family member ever had a reaction to anesthesia?                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you allergic to any medications?  | <input type="checkbox"/> | <input type="checkbox"/> |
| If you answered <b>YES</b> , please give the name of the medication(s) and the reaction(s): |                          |                          |

This page was reviewed by Dr. Yoash Enzer

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

Name: \_\_\_\_\_

Date: \_\_\_\_\_

### SOCIAL HISTORY

Do you smoke now? ☐ Yes ☐ No

If yes, quantity smoked per day: \_\_\_\_\_

Smoked a total of \_\_\_\_\_ years.

Average weekly / monthly alcoholic beverage consumption: \_\_\_\_\_

### OCULOPLASTIC REVIEW OF SYSTEMS

Place a check if you have any of the following problems:

- |  |  |
|--|--|
| <input type="checkbox"/> Dry eyes                | <input type="checkbox"/> Lid/Face Spasms                         |
| <input type="checkbox"/> Foreign body sensation  | <input type="checkbox"/> Facial pain/numbness                    |
| <input type="checkbox"/> Red eyes                | <input type="checkbox"/> Facial weakness/palsy                   |
| <input type="checkbox"/> Itchy eyes              | <input type="checkbox"/> Eye/eyelid/facial injury                |
| <input type="checkbox"/> Sticking/crusted lashes | <input type="checkbox"/> Decreased/poor vision                   |
| <input type="checkbox"/> Sty or chalazion        | <input type="checkbox"/> Loss of vision                          |
| <input type="checkbox"/> Pus around the eye      | <input type="checkbox"/> Double vision                           |
| <input type="checkbox"/> Wet eyes                | <input type="checkbox"/> Eye that turns in/out                   |
| <input type="checkbox"/> Eye(s) that bulge/sink  | <input type="checkbox"/> Runny nose                              |
| <input type="checkbox"/> Eye pressure            | <input type="checkbox"/> Sinus problems                          |
| <input type="checkbox"/> Drooping eyelid         | <input type="checkbox"/> Eye/lid/facial surgery                  |
| <input type="checkbox"/> Eyelid retraction       | <input type="checkbox"/> Other ( <i>please elaborate below</i> ) |
| <input type="checkbox"/> Thyroid eye disease     |  |
| <input type="checkbox"/> Eyelid growth           |  |

### SYSTEMIC REVIEW OF SYSTEMS

Place a check if you have any problems in the following areas, and give details on the back of the page.

- ☐ Constitutional (recent change in weight, energy level, temperature, etc.)
- ☐ Neurologic (brain, spinal cord, etc.)
- ☐ Head, ears, nose, throat, and sinuses
- ☐ Dermatologic (skin, hair, nails)
- ☐ Heart / Circulation (including blood vessels)
- ☐ Respiratory (lungs and breathing passages)
- ☐ Gastrointestinal (stomach, intestines, rectum)
- ☐ Genitourinary (genitals, kidneys, bladder, prostate)
- ☐ Hematologic (blood, clotting, and lymph glands)
- ☐ Endocrine (thyroid, diabetes, pancreas, etc)
- ☐ Rheumatologic (joints, autoimmune conditions)
- ☐ Allergy
- ☐ Psychiatric

### SURGICAL HISTORY

List all surgeries and their dates (use the back of the page if necessary):

### ADDITIONAL INFORMATION

This page was reviewed by Dr. Yoash Enzer

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



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### RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

**All Patients:** I authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits or cosmetic services directly to Enzer & Associates, P.C. In the event you are required to proceed with any collection proceedings, **I agree to be responsible for all reasonable billing fees associated with the collection of my debt, including but not limited to 1.5% per month interest on the outstanding balance, plus attorney and/or collections fees (up to 33.3%).** I agree that I will be responsible to pay Dr. Enzer for all services rendered, including those not covered, co-insurance balances, or denied for payment by my insurance company.

**Medicare Patients:** I request that payment of authorized Medicare benefits be made to Enzer & Associates, P.C. for any and all services furnished to me by said medical company. I authorize any holder of medical or other 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.

Signature:

Date:

### MISSED APPOINTMENT POLICY

Any appointment missed, cancelled, or rescheduled less than one (1) business day will be subject to the following fees. Appointment fees may be charged to a credit card. Should you wish to be billed, there will be an additional \$25.00 fee from our billing company. All appointment fees must be paid in full prior to booking another appointment. **Leaving a message with our answering service the night before a scheduled appointment does not constitute one (1) business day notice.** I have read and agree to the terms of the appointment policy as stated above.

#### Dr. Enzer Missed Appointment Fees

Follow-up = \$50.00      New Patient = \$100.00  
20 minute visit = \$100.00      30+ minute visit = \$150.00

#### Registered Nurse/Licensed Esthetician Fees

One half of treatment cost

Signature:

Date:

### PATIENT PHOTOGRAPHY CONSENT

Enzer & Associates, P.C. may need to photograph you to document a medical condition, help with the diagnosis and/or treatment of a condition, submit for insurance billing requirements, and/or to help plan details of surgery. Photographs taken for these clinical reasons do not require your written permission. Your provider **does** need your written permission to use your photographs and details regarding medical services for the non-clinical reasons below. I hereby authorize Enzer & Associates, P.C. to photograph me for the following purposes.

- For external not-for-profit educational purposes outside Enzer & Associates, P.C. including teaching, lectures, medical publications, and presentations at professional conferences.
- To show current or future patients of Enzer & Associates, P.C. for the purpose of education and consultation. This may include, but is not limited to, printed patient education materials and/or website photo albums.

**YES NO**

☐ ☐

☐ ☐

Enzer & Associates, P.C. will take all safeguards to protect my privacy and confidentiality in the use of these photographs. I consent to release any photo other than a full face frontal or side ("identifying") photo for the uses above without inspection or approval on my part of the finished product or specific use to which these photographs may be applied. I understand that although my name will not be used, it may be possible to identify me from a photo. Copies of the photos may be released to me if I ask for them. I may revoke my authorization at any time by written request.

Signature:

Date:




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## HIPAA ACKNOWLEDGEMENT AND PRIVACY PREFERENCES

I, \_\_\_\_\_, understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have had the opportunity to read and understand your Notice of Privacy Practices regarding the uses and disclosures of my health information (a hard copy is not been enclosed; please ask receptionist if you wish to read the full text or receive a hard copy). I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I may also request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

|   |            |   |   |                         |   |   |            |   |   |                         |   |   |            |   |   |                         |   |   |      |   |   |       |   |   |  |
|---|------------|---|---|-------------------------|---|---|------------|---|---|-------------------------|---|---|------------|---|---|-------------------------|---|---|------|---|---|-------|---|---|--|
| <input type="checkbox"/> <b>I give my permission to be contacted by the following option(s):</b><br><br><table><tr><td>Home phone</td><td>Y</td><td>N</td></tr><tr><td>May we leave a message?</td><td>Y</td><td>N</td></tr><tr><td>Cell phone</td><td>Y</td><td>N</td></tr><tr><td>May we leave a message?</td><td>Y</td><td>N</td></tr><tr><td>Work phone</td><td>Y</td><td>N</td></tr><tr><td>May we leave a message?</td><td>Y</td><td>N</td></tr><tr><td>Mail</td><td>Y</td><td>N</td></tr><tr><td>Email</td><td>Y</td><td>N</td></tr></table> | Home phone | Y | N | May we leave a message? | Y | N | Cell phone | Y | N | May we leave a message? | Y | N | Work phone | Y | N | May we leave a message? | Y | N | Mail | Y | N | Email | Y | N | <input type="checkbox"/> <b>I do NOT give my permission to be contacted by Enzer &amp; Associates, PC.</b> I assume full financial responsibility for any and all missed appointments.<br><br> |
| Home phone  | Y          | N |   |                         |   |   |            |   |   |                         |   |   |            |   |   |                         |   |   |      |   |   |       |   |   |  |
| May we leave a message?   | Y          | N |   |                         |   |   |            |   |   |                         |   |   |            |   |   |                         |   |   |      |   |   |       |   |   |  |
| Cell phone  | Y          | N |   |                         |   |   |            |   |   |                         |   |   |            |   |   |                         |   |   |      |   |   |       |   |   |  |
| May we leave a message?   | Y          | N |   |                         |   |   |            |   |   |                         |   |   |            |   |   |                         |   |   |      |   |   |       |   |   |  |
| Work phone  | Y          | N |   |                         |   |   |            |   |   |                         |   |   |            |   |   |                         |   |   |      |   |   |       |   |   |  |
| May we leave a message?   | Y          | N |   |                         |   |   |            |   |   |                         |   |   |            |   |   |                         |   |   |      |   |   |       |   |   |  |
| Mail  | Y          | N |   |                         |   |   |            |   |   |                         |   |   |            |   |   |                         |   |   |      |   |   |       |   |   |  |
| Email   | Y          | N |   |                         |   |   |            |   |   |                         |   |   |            |   |   |                         |   |   |      |   |   |       |   |   |  |

Signature:

Date:



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## *Directions to Southside Medical Center at 120 Dudley Street*

**Driving North on I-95:** Take exit 18 for Thurbers Ave. Bear left onto Thurbers Ave. and turn right at the first light onto Eddy St. After .08 mi. turn left onto Dudley St. Free parking is in gated lot on left, directly across from Women & Infants Hospital. We are on the first floor in Suite 104.

**Driving South on I-95:** Take exit 19 for Eddy Street immediately after the split for I-95. Bear left on the exit towards Eddy St. Merge right onto Eddy St., and then turn right at the 1st light onto Dudley St. Continue 1/4 mi. on Dudley St. Free parking is in gated lot on left, directly across from Women & Infants Hospital. We are on the first floor in Suite 104.

**Driving West on I-95:** Merge onto I-95 South and take exit 1B (the first exit on the right) for Eddy St. At the light turn right onto Eddy St. At the next light take a left onto Dudley St. Continue on Dudley St. for 1/4 mi. Free parking is in gated lot on left, directly across from Women & Infants Hospital. We are on the first floor in Suite 104.

## *Policies*

**Office Hours:** Our normal hours are 9:00 a.m. to 5:00 p.m. Monday through Friday. However, you may call the office any time and all emergencies will be relayed to Dr. Enzer immediately.

**Appointments:** All visits are scheduled by appointment. It is our policy to book ample time for your visit with Dr. Enzer and we do our best to minimize patient waiting time. **If you should need to cancel or reschedule an appointment, we require at least 24 hours advance notice;** otherwise you will be responsible for the visit fee and any other necessary billing or collection fees.

**Registration Materials:** In order to provide optimum care, Dr. Enzer requests that you complete a medical history questionnaire prior to your visit with our office. You may do this by downloading the registration forms from [www.doctorenzer.com](http://www.doctorenzer.com), requesting them by mail, or coming to the office ten minutes early to fill out the forms. **Please bring a complete medication list** to your visits. If you wear contact lenses, you should bring a case for them as well as your glasses.

**Insurance Coverage:** For our medical patients, Dr. Enzer participates with the major area plans. Many plans require that the patient obtain permission to see Dr. Enzer for the initial and each follow-up visit. This is your responsibility. Please bring your insurance card (s) to the office so we can obtain accurate billing information. **If your insurance plan decides not to cover Dr. Enzer's services, you will be responsible for payment of the bill.** To contain costs, all payments are required at the time of service. We accept cash, checks, VISA® or MASTERCARD®. There is a billing fee for any unpaid balances. By minimizing our expenses, we help keep our fees competitive.

**Reconstructive Procedures:** Many reconstructive procedures will be covered by insurance plans. Our staff will help obtain this information in advance if possible. We make no representation or guarantee regarding what costs an insurance company will cover. All non-covered services will be the responsibility of the patient.

**Cosmetic Surgery Costs:** The cost of cosmetic surgery is not covered by insurance plans, and thus is the full responsibility of the patient. For more information regarding cosmetic surgery policies and fees, please go to the Office Policies section on our website at [www.doctorenzer.com](http://www.doctorenzer.com).