YOASH R. ENZER, MD, FACS
Cosmetic, Laser, and Oculofacial Plastic Surgery
ASHLEY L. WRIGHT, FNP
Aesthetic Nurse Practitioner
120 Dudley Street, Suite 104 | Providence, RI 02905
Phone (401) 274-4464 | Fax (401) 831-0710 | 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	☐	☐
High blood pressure	☐	☐
Thyroid problems	☐	☐
Heart attack/irregular beats	☐	☐
Emphysema/asthma	☐	☐
Poor clotting/bruise easily	☐	☐
Poor circulation	☐	☐
Stroke	☐	☐
Cancer	☐	☐
Eye problems	☐	☐
Other significant condition	☐	☐

Please elaborate below:

HAVE YOU EVER BEEN DIAGNOSED WITH:

	Yes	No
Hepatitis?	☐	☐
HIV?	☐	☐
MRSA? *(methicillin resistant Staphylococcus aureus)*	☐	☐
If so, when? _____		
VRE? *(Vancomysin resistant Enterococcus)*	☐	☐
If so, when? _____		
Have you been in the hospital or any other overnight facility in the last six months?	☐	☐
If so, when? _____		
Sleep apnea?	☐	☐
Do you use a machine to breathe at night?	☐	☐

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?	☐	☐
Do you take non-steroidal anti-inflammatory medication (Advil, Aleve, Motrin, ibuprofen, etc.)?	☐	☐

ALLERGIES

	Yes	No
Have you or a family member ever had a reaction to anesthesia?	☐	☐
Are you allergic to any medications?	☐	☐

If you answered **YES**, 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:

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

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

Nurse Provider/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:

	YES	NO
• For non-profit educational purposes outside Enzer & Associates, P.C., including teaching, lectures, medical publications, and presentations at professional conferences.	☐	☐
• To show current or future patients for the purpose of education and consultation. This may include, but is not limited to, printed patient education materials, social media, and/or website photos. **Our policy is to not post any patient photo to social media or our website Photo Gallery without your written approval.**	☐	☐

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.

☐ **I give my permission to be contacted by the following option(s):**

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

☐ **I do NOT give my permission to be contacted by Enzer & Associates, PC.** I assume full financial responsibility for any and all missed appointments.

Permitted **Uses & Disclosures covered by HIPAA**: I hereby authorize Enzer & Associates, PC to disclose the following information to the named person(s) below:

___ Appointment date/times ___ Financial/Insurance ___ Medical (diagnosis/lab results) ___ Care Plan

Name: _____ Relationship: _____ Phone #: _____

Signature: Date:

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Directions/Policies

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-195. 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-195: 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 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.

Office Information & Policies

Office Hours: Our normal hours are 9:00 a.m. to 5:00 p.m. Monday through Friday. All emergencies calls are advised to call the office, your message will be relayed to Dr. Enzer or the covering provider immediately.

Appointments: All visits are scheduled by appointment. It is our policy to book ample time for your visit with our Providers, and we do our best to minimize patient waiting time. **If you should need to cancel or reschedule an appointment, we require minimum – 24 buisness 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, our Providers request that you complete a medical history questionnaire prior to your visit. You may do this by downloading the registration forms from **www.doctorenzer.com**, requesting them by mail, or e-mail, or coming into the office 15 minutes early to fill out the forms. **Please bring a complete medication list (including over the counter/herbal supplements), photo ID, and insurance card(s) (if applicable)** to your visits. If you wear contact lenses, 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, and all major credit cards. 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**.

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Patient Name: _____ **Date:** _____

Telemedicine Patient Consent Form

Telemedicine is a mode of delivering healthcare services and public health utilizing information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, and self-management of patients at a distance from health care providers.
For further details visit: https://health.ri.gov/healthcare/about/telemedicine/

1. **PURPOSE:** The purpose of this form is to obtain your consent to participate in a telemedicine consultation to discuss symptoms in real-time for health insurance covered medical issues and/or cosmetic concerns, treatment options, and prescriptions if warranted.
2. **NATURE OF TELEMEDICINE CONSULT:** During the telemedicine consultation:
   a. Details of your medical history, examinations, x-rays, and tests will be discussed with you, and any other people you invite, and possibly including other health professionals using interactive video (FaceTime, Skype, Zoom, or private HIPPA-compliant telemedicine platforms) audio, and telecommunication technology.
   b. A physical examination of you may take place.
   c. A non-medical technician may be present in the telemedicine studio to aid in the audio or video transmission. Medical assistants from our office may also participate.
   d. Video, audio and/or photo recordings may be taken during the procedure(s) or service(s).
3. **MEDICAL INFORMATION & RECORDS:** All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this telemedicine interaction to researchers or other entities shall not occur without your consent.
4. **CONFIDENTIALITY:** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and Rhode Island state law apply to information disclosed during telemedicine consultation.
5. **RIGHTS:** You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
6. **DISPUTES:** You agree that any dispute arriving from the telemedicine consult will be resolved in Rhode Island, and that Rhode Island law shall apply to all disputes.
7. **RISKS, CONSEQUENCES & BENEFITS:** You have been advised of all the potential risks, consequences and benefits of telemedicine (HIPPA and the HITECH act). Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on the form and the telemedicine consultation. All your questions have been answered, and you understand the written information provided above.

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8. **RESOURCES NEEDED TO PARTICIPATE**: In order to participate in telemedicine, you will need to be able to do the following:
   a. Download the appropriate *new patient forms* (cosmetic or medical) from our website, complete, and send back (email, fax, mail) to our office before your virtual appointment.
      1. Attach a copy of your photo ID and insurance card(s) with your new patient forms.
   b. Access a smart phone with video capability, IPAD, or a computer with web cam and microphone.
   c. Video platform: FaceTime, Skype, Zoom, or our private HIPPA-compliant telemedicine platform.

I have read and fully understand the above statements. I agree to participate in telemedicine consultations.

Patient Signature	**Date**
Physician Signature	**Date**