Craig Dufresne, M.D., F.A.C.S.
Reza Kordestani, M.D.

PATIENT REGISTRATION

Full Name of Patient: _____ Date of Birth: _____ Age: _____

Name of Spouse/Parent (if applicable): _____

Home Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Work Phone: (____) _____ Marital Status: _____ Sex: _____ SSN:_____

Emergency Contact: _____ Telephone: _____

Employer: _____

Primary Insurance: Secondary Insurance (if applicable):

Ins. Co. Name: _____ Ins. Co. Name: _____

*** Please present your insurance card(s) and a photo I.D. at the front desk. If the patient is a minor or a dependent, please fill out the following information:**

Subscriber's Name: _____ Subscriber's Name: _____

Subscriber's Date of Birth: _____ Subscriber's Date of Birth: _____

Relationship to Patient: _____ Relationship to Patient: _____

Reason for Consultation: _____

Patient Referral: _____ Physician Referral: _____ Other: _____

I acknowledge that I am responsible for services rendered, not my insurance company. I agree to pay in full at the time of service. Any exception to service rendered that is billed, I authorize payment to be paid directly to the physician.

I hereby authorize you to release my medical information when appropriate (for medical and/or insurance purposes only). I also authorize you to request copies of my medical records from other physicians and/or medical facilities in conjunction with my care.

Signature: _____ Date: _____

A copy of the HIPAA Privacy Practice has been provided to me. I understand that it will be updated every year and will be made available to me upon request. _____

MEDICAL HISTORY

Full Name of Patient: _____ Today's Date: _____

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

Are you under the care of a physician? □ Yes □ No If so, please list name: _____

When were you last seen by your regular physician? _____

Have you ever had surgery? □ Yes □ No If yes, please explain: _____

_____

Have you or any immediate family member had any problems with anesthesia? □ Yes □ No

If yes, please explain: _____

Please list your previous hospitalizations: _____

Are you taking any medications? □ Yes □ No If yes, please list: _____

_____

Are you taking any non-prescription medications? (vitamins, supplements, herbs) □ Yes □ No If yes, please list: _____

_____

Do you have any allergies? □ Yes □ No If yes, please name: _____

Do you have a latex allergy? □ Yes □ No

Do you take Aspirin regularly? □ Yes □ No

Do you smoke? □ Yes □ No If yes, how many packs per day? _____

Do you drink alcohol? □ Yes □ No If yes, how much? _____

Do you exercise regularly? □ Yes □ No

Are you pregnant? □ Yes □ No

Do you have a history of any of the following?:

Asthma	□ Yes □ No	Thyroid Problems	□ Yes □ No
Bronchitis	□ Yes □ No	Anemia	□ Yes □ No
High Blood Pressure	□ Yes □ No	Stroke	□ Yes □ No
Liver Problems	□ Yes □ No	Glaucoma	□ Yes □ No
Ulcers	□ Yes □ No	Hiatal Hernia	□ Yes □ No
Bleeding Problems	□ Yes □ No	Arthritis	□ Yes □ No
Cancer	□ Yes □ No	Seizures	□ Yes □ No
Blood clots in lungs or legs	□ Yes □ No	Diabetes	□ Yes □ No
High Cholesterol	□ Yes □ No	Blood Transfusion	□ Yes □ No
Sleep Apnea	□ Yes □ No	Other Medical Problems	□ Yes □ No

If you answered "yes" to any of the above, please explain: _____

Do you now, or have you ever used recreational drugs? □ Yes □ No If so, when was the last time? _____

Have you ever taken any antidepressant or psych medications? □ Yes □ No If yes, please list medication and date taken:

_____

Have you ever had a blood transfusion? □ Yes □ No If so, when? _____

How would you describe your present health? □ Excellent □ Good □ Fair

FINANCIAL POLICIES

As patients approach surgery, they frequently need information about the various payment options and have questions about their potential insurance benefits. We hope the following information will be helpful:

Insurance Coverage

- Cosmetic surgery is not covered by insurance.
- Dr. Dufresne & Dr. Kordestani are Out-of-Network providers. We do not participate as an insurance provider for any company, including Tricare. As a courtesy, we will submit your claim(s) to your insurance company. Any insurance reimbursements we do receive will be reimbursed to you.
- Please discuss all arrangements regarding payment of your account with us.

Payment Options

- At the time of scheduling, a 50% deposit of the doctor's fee is required to reserve the operating room time. The balance is due three (3) weeks prior to the date of surgery, at the pre-op visit. Surgery revisions must be completed within twelve (12) months and are subject to a surgical charge.
- **Cash or check:** Personal check, cashier's check or cash.
- **Credit cards:** Visa, Master Card, American Express.
- **CareCredit:** We accept CareCredit financing. Restrictions may apply.

Cancellation Policy

- If you need to cancel your regular/follow-up appointment, please give our office a 24 hour notice otherwise you may be subject to a cancellation fee.
- If you have any questions or need assistance with financial matters, please phone our office at (703) 207-3065.
- I acknowledge that I am responsible for the services rendered, not my insurance company. I agree to pay in full at the time of service. Any exception to service rendered that is billed, I authorize payment to be made directly to Craig Dufresne & Associates, M.D.
- **Authorized signature –** I hereby authorize you to release my medical information when appropriate (for medical and insurance purposes only).

Signature: _____ Date: _____

WAIVER FOR MEDICAL SERVICES

I, _____, understand that I am choosing to see Dr. Dufresne/ Dr. Kordestani outside of my insurance plan. By doing so, I understand that I am fully responsible for all medical billing incurred as the result of any visit to Craig Dufresne & Associates, M.D.

For patients currently enrolled in Medicare:

MEDICARE SERVICES

I, _____, understand that I am fully responsible for payment of any visit or procedure with Dr. Dufresne/ Dr. Kordestani that is billed to Medicare and rejected as a non-covered service.

Signature: _____ Date: _____