Sheldon M. Lincenberg, M.D.
Georgia Plastic Surgery, P.C.
Patient Registration Form

Account # _____
Date _____

Patient's Name _____
(Last) (First) (Middle) (Name Called)
Home Address _____ **Telephone** ( ) _____
City _____ State _____ County _____ Zip Code _____
Marital Status _____ Age _____ **Date of Birth** _____ Race _____
Cell Phone ( ) _____ Email Address _____
Employed By _____ Occupation _____
Business Address _____ Telephone ( ) _____

_____
Spouse's Name _____ Telephone ( ) _____
(Or Responsible Party) Spouse/Responsible Party Birth Date _____
Home Address (if different from patient) _____
Spouse employed by _____ Occupation _____
Business Address _____ Telephone ( ) _____

_____
Nearest Relative _____ Relationship _____
Home address _____ Telephone ( ) _____

_____
Referred by _____

INSURANCE INFORMATION

Patient's social security # _____ Insured's social security # _____
Insurance Carrier _____ Insurance Telephone ( ) _____
Policy Holder's Name _____ Policy Holder's Birth Date _____
Your Relation to Policy Holder _____
Policy # _____ Group # _____

Authorization of Patient (Required Where Photograph Might Reveal Patient's Identity). In order to assist in the dissemination of medical or scientific knowledge or in the improvement of medical diagnosis and treatment, I hereby authorize Georgia Plastic Surgery, P.C. to take, publish, display, or otherwise use photographs made and information related to my case. It is understood and agreed that my name will not be used or in any way disclosed in connection therewith. I waive the rights that I may have to any claims for payment or royalties in connection with any exhibition, televising, or publication of these photographs.
Signature of Patient (or legal representative) _____

I, _____ hereby make assignment of all disability, surgical, medical and major medical insurance benefits to Georgia Plastic Surgery, P.C. I also hereby give authorization for Georgia Plastic Surgery, P.C. to release any medical information necessary to execute an assignment of benefits. I understand that regardless of any insurance coverage I might have, I am personally responsible for all charges to this account. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, you will be billed for that balance. Any balances over 60 days old will be subject to an interest fee of 1½ % of the balance due. You will be responsible for any charge denied by your insurance company, deemed not medically necessary and/or not covered. Charges reduced by Usual and Customary Ratings, will be evaluated and possibly charged to you as well. I further agree, in the event of non-payment, to bear the cost of collection and/or court cost and reasonable legal fees should this be required.
Signature of Patient (or legal representative) _____

Sheldon M. Lincenberg, M.D.
Georgia Plastic Surgery, P.C.
PATIENT'S MEDICAL HISTORY

Name:_____ Account #:_____

Family Doctor's Name & Address: _____

_____

_____

Pharmacy Name and number:_____

Reason for Visit:_____

PAST MEDICAL HISTORY (Please list ALL ACTIVE & PAST Medical Problems below) ☐ **NO SIGNIFICANT PROBLEMS**

Condition	Year Diagnosed	Condition	Year Diagnosed

PAST SURGICAL HISTORY (Please list ALL surgeries you have had-include surgeon's name if possible) ☐ **NO SURGERIES**

Procedure/ Surgeon	Date	Procedure/ Surgeon	Date

MEDICATIONS (List Below) ☐ **NO CURRENT PRESCRIPTION, OVER-THE-COUNTER, OR HERBAL MEDS TAKEN**

Medication Name	Strength	Number	Route	Frequency	Reason
Example: Tylenol	*325 mg*	*2 capsules*	*By mouth*	*Every 6 hours*	*For pain*

ALLERGIES Please list medications that you have had adverse reactions to, including over-the-counter. ☐ **NO ALLERGIES**

Medication Allergy	Reaction Type	Medication Allergy	Reaction Type

Height _____ Weight _____

Do you smoke? _____ How much? _____

General	Y	N
Fevers		
Night Sweats		
Weight Loss>10 pounds (not intentional)		
Head and Neck:		
Cataracts		
Glaucoma		
Bell's Palsy		
Shingles		
Skin Cancer		
Psychiatric		
Anxiety		
Depression		
Hypersomnia (excessive sleeping)		
Insomnia (unable to sleep)		
Hematology		
Easy Bruising		
Enlarged Lymph Nodes		
Nose Bleeds		
Prolonged Bleeding		

CARDIOVASCULAR	Y	N
Chest Pain		
Hypertension (high blood pressure)		
Palpitations (heart skipping beats)		
Shortness of Breath		
Gastrointestinal		
Heartburn		
Diarrhea		
Constipation		
Neurologic		
Headaches		
Seizures		
Weakness		
Other		
Diabetes		
DVT (blood clots in legs)		

FAMILY HISTORY Blood-related relatives with any of the following-please list relative.

Disease (list relative affected)	Y	N
Cardiovascular (in family)		
Heart Attack		
Stroke		
Heart Disease		
High Blood Pressure		
Endocrine (in family)		
Diabetes (if yes, requires insulin?)		
Thyroid Disease		
Parathyroid Disease		

Disease (list relative affected)	Y	N
Hematologic/Oncologic (in family)		
Thyroid Cancer		
Easy Bleeding or Bruising		
Frequent Infections		
Other Diseases In Your Family		
Cancer		
Breast melanoma		
Are there other diseases in your family?		
If yes, please specify below:		

FEMALES ONLY: PREGNANCY / GYN HISTORY

Number of pregnancies? _____ Deliveries?_____ Date of last menstrual period?_____

Have you had any illness not mentioned here? (If yes, please explain.)_____

_____

_____

Have you had any injuries or broken bones? (If yes, please explain.)_____

_____

Have you ever had a blood transfusion? (If yes, when?)_____

Do you drink alcoholic beverages? _____How much? _____

Are you currently under contract with an attorney (lawyer)? _____ Is it related to this visit? _____ (If yes, please explain.)

_____

_____

_____

_____

Signature: _____ Date:_____

Financial Agreement

I, _____ understand that I am personally responsible for all charges I incur as a patient at Georgia Plastic Surgery, P.C., regardless of any insurance coverage I may have. I also understand that my insurance coverage is a contract between myself and my insurer, and that in the event of non-payment, I will be held responsible for my balance, not my insurance company.

All estimated patient financial responsibility is due to Georgia Plastic Surgery, P.C. ten days prior to any procedure. Georgia Plastic Surgery, P.C. will allow insurance companies a reasonable amount of time to pay on a claim (usually 45 days). After this reasonable period of time has passed without payment, the balance will be billed to the patient for payment.

Further, in the event of non-payment, I understand that I will bear the cost of collection and/or court cost and reasonable legal fees should this be required to collect the balance of my account. Should my account be turned over to a collection agency, the collection agency's fee will be added to my balance for collection. I understand that Georgia Plastic Surgery, P.C. charges patients $35.00 for returned checks.

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. Lincenberg will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

Patient Signature _____

Date _____

Sheldon M. Lincenberg, M.D.
Georgia Plastic Surgery, P.C.
Deposit Requirements

When it has been determined that insurance coverage will apply to your surgery, there will be a deposit requested from the patient at the time of scheduling. The deposit will be based on the amount of the cost that will be considered patient responsibility by your insurance company. We will not schedule surgery until this portion is paid.

ACKNOWLEDGEMENT:

I have read the above statement and fully understand that if surgery is considered, a **NON REFUNDABLE** deposit will be requested from me prior to the scheduling of surgery.

Signed_____Date_____

Sheldon M. Lincenberg
Georgia Plastic Surgery, P.C.

In addition to cosmetic surgeries such as facelifts, eyelid lifts, liposuction, breast reshaping, tummy tucks, and nose reshaping, Georgia Plastic Surgery offers several other services that may be of interest. To help us help you reach your full cosmetic potential, please check the areas of interest.

___ Facial Skin Health

___ Deep Facial Peels

___ Laser Resurfacing of Skin

___ Lip Enlargement

___ Lip Reduction

___ Botox Therapy

___ Facial Fillers

___ Spider Vein Injections

----- Non-Surgical Fat Removal

----- Core Strengthening and Optimization