PLEASE COMPLETE THE FOLLOWING INFORMATION

(If there are any changes in the future, please let us know)

Last Name: _____ First: _____ MI: ____ Date_____

Home Address:_____ Apt._____

City:_____ State:_____ Zip:_____

Home Phone: ( ) _____--_____ Cell: ( ) _____ --_____

Work Phone: ( ) _____--_____ Occupation: _____

E-mail (Please print clearly): _____@_____

You may contact me by: CELL HOME PHONE MAIL E-MAIL ALL NONE (please circle all that apply)

Date of Birth: _____/_____/_____ Age: _____ SSN: ___ - __ - ____

Sex: M F Marital Status: M S D W Partner (please circle) No. of Children _____

How did you hear about our Practice? (Please check all that apply and circle the one most important)

___Physician ___Google ___Insurance company website ___Friend/family ___Zocdoc

Other (Please Specify):_____

If search engine, please indicate the words that you typed in to find us:

_____

Have you seen Dr. Wolfeld before at any other office: ___No ___Yes *If Yes, where*_____

If you were referred please indicate: (Circle One) Physician Family Friend Other: _____

Name_____Address:_____

If Friend, permission to send thank you letter? Yes or No (circle)

INSURANCE INFORMATION: (Please also present your card to the front desk.)

Insurance Provider: _____ Policy No: _____

Are you the PRIMARY HOLDER of your insurance? __YES __NO

If NO: Name of Insured: _____ Relationship to Insured: _____

Insured DOB_____ Insured SSN# _____

Michael Wolfeld, MD
110 East 55th Street
New York, NY 10022
Phone: 212.281.1000

NOTICE OF YOUR LEGAL RIGHTS TO MEDICAL INFORMATION PRIVACY

Your medical information in this office is used only in specific instanced governed by law. Under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), patients have certain legal rights to privacy regarding their healthcare information.

Understand that this information is used but limited to:

- Communication with other medical providers to conduct, plan, and participate in the treatment of your healthcare directly or indirectly in emergency and non-emergency situations.
- Conduct normal healthcare operations such as assessments and certifications.
- Obtain payment information from insurance companies.

Your medical information will not be used for any other purpose unless this office receives written permission from you

I have read and understand my Notice of Privacy Rights to Medical Information Privacy.

Patient's Name: _____

Relationship to Patient: Self or Other _____

Signature: _____

Date: _____

Wolfeld Plastic Surgery, LLC
110 East 55th Street, 14th Floor
New York, NY 10022
212-281-1000

Patient Name: Date:

What is your reason for your visit today?

Other than the services we have already provided for you, what additional services would you like to learn about? Please check all that apply.

- ☐ Skin care advice
- ☐ Skin care products
- ☐ Facial Injectables/ Fillers
- ☐ Facial fine lines/wrinkles
- ☐ Thin lips
- ☐ Tummy Tuck
- ☐ Chemical peel
- ☐ Blotchy skin
- ☐ Breast lift
- ☐ Brown spots/age spots/freckle
- ☐ Drooping brow
- ☐ Drooping eyelids
- ☐ Nose size or shape
- ☐ Facial fullness/drooping
- ☐ Mole removal
- ☐ Neck wrinkles
- ☐ Scar revision
- ☐ Breast size
- ☐ Abdominal area
- ☐ Hips
- ☐ Thigh Lift
- ☐ Facial Contouring
- ☐ Body Contouring
- ☐ Liposuction

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		*True Age*		*Older Than*
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the look of my body, including my tummy, thighs, breasts, buttock, and arms

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

How did you hear about us?

☐ My physician	*Full name:*
☐ My insurance company provider	*Name:*
☐ A friend or family member	*Name:*
☐ Internet	*Site:*
☐ The Physician/Practice website	*Site:*
☐ Seminar	*Date/location:*
☐ Other	

☐ Approval to contact you.
☐ Approval to send you information on products and services (including special offers)

Best phone number to reach you:

Email address:

☐ *I'm not interested in any additional services provided at this time*