

Delaware Valley
Plastic Surgery, P.A.

Evan Sorokin M.D., F.A.C.S.
Plastic & Cosmetic Surgery



Date: _____

PATIENT REGISTRATION

Patient's Name _____

Address _____

City _____ State _____ Zip _____

Telephone numbers Home _____

Cell _____

Work _____

Email Address _____

Date of Birth _____

Social Security Number _____

Employer _____

What brings you to the office today ? _____

How did you learn about us ?

my friend _____

My physician _____

Advertisement (if you can recall which one: _____)

Referred by website (if you can recall which one: _____)

1734 Marlton Pike East (Route 70) Cherry Hill, New Jersey 08003
Telephone 856.797.0202 Fax 856.751.7700
Email contact@delawarevalleyplasticsurgery.com

Name _____

Marital Status Single Married Widowed Divorced

Female Male Age _____ Height _____ Weight _____

Do you have any children? Yes No If so, how many? _____ Ages _____

Have you seen any other surgeon for this issue? Yes No Who? _____

Emergency Contact : Name _____ Number _____

Primary physician : Name _____ Number _____

Pharmacy : Name _____ City _____ Number _____

Allergies to any medicines or foods _____

Any current medications (including birth control, aspirin, herbs, vitamins) :

Do you smoke ? Yes No Quit

Do You drink alcohol ? Yes No

Do you use any drugs such as marijuana, cocaine, etc ? Yes No

Do you take any diet pills ? Yes No

Have you ever had a mammogram ? Yes No When? _____

Name _____

Have you had any previous surgery (including cosmetic)? Please list.

Review of systems:	Yes	No		Yes	No
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Anesthesia problems	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Back problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots in legs	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>
Blood Pressure Problems	<input type="checkbox"/>	<input type="checkbox"/>	Keloids	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Breakdown	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Nose & Throat Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Passing out during exercise	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol high?	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric problems	<input type="checkbox"/>	<input type="checkbox"/>
Corrective glasses	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Scarring Problems	<input type="checkbox"/>	<input type="checkbox"/>
Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Ear problems	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Eye problems	<input type="checkbox"/>	<input type="checkbox"/>	Stomach problems	<input type="checkbox"/>	<input type="checkbox"/>
Family anesthesia problem	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Family breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/>
Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>			

Is there anything else you have been treated for either by a physician or an alternative care provider? _____

NOTICE OF PRIVACY PRACTICES (HIPAA COMPLIANCE) Evan Sorokin MD

The misuse of Personal Health Information (PHI) has been identified as a national problem causing inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity when performing services to our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We realize there is always room for improvement! It is our policy to listen to our employees and our patients. If you feel your privacy has been compromised in any way, please ask to speak with our compliance office or express your concern to your physician.

Please read the following "Notice of Privacy". After reading, sign and return this form to the receptionist. If you have any questions, please ask. Thank you.

NOTICE OF PRIVACY

The department of Health and Human Services has established a "Privacy Rule" to help insure that personal health information (PHI) is protected for privacy. The Privacy Rule provides standards for health care providers to follow when disclosing patient health information that is needed to carry out proper treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum amount of necessary information to only those we feel are in need of your health care information. We strive to provide the best health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. If you want to request restrictions pertaining to parties you do not want PHI released to please tell our compliance officer and it will be documented in your chart. You will be asked to authorize release of PHI to any party that is directly connected to your treatment, payment, or health care operations.

If you have any questions, comments, or objections to the privacy policy on this form, please ask to speak with our compliance officer. You have the right to review our entire privacy policy manual upon request. Please sign this form to acknowledge that you have read this patient notice of privacy.

Signature : _____ Date : _____

CONSENT FOR PHOTOGRAPHS AND DIGITAL IMAGES

I certify that I am the Patient or Legal Guardian of the above named patient, and hereby consent that digital photographs will be taken by my physician Dr. Sorokin and/or a photographer approved by the physician. I recognize that Dr. Sorokin uses my photographs and images as part of the medical record. I grant permission for Dr. Sorokin to utilize my images for purposes he sees fit such as research, education of other patients, and advertising. I understand that this may result in a loss of my anonymity. I understand that if I object to display of my photographs I will notify Delaware Valley Plastic Surgery, PA in writing and this will be honored. I understand that any image or photograph taken is the sole property of Delaware Valley Plastic Surgery, PA.

Patient/Guardian Signature: _____ Date: _____

AGREEMENT AS TO RESOLUTION OF CONCERNS

I understand that I am entering into a contractual relationship with Dr. Sorokin for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Physician, I, the patient/guardian and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Physician.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use American Board of Medical Specialties ("ABMS") board-certified expert medical witness(es) in the same specialty as Physician. I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and / or code of conduct defined for expert witnesses by the American Society of Plastic Surgeons.

In further consideration for this, Physician agrees to the same stipulations. *This agreement does not mean I give up my rights for litigation, it only means I would use experts in Dr. Sorokin's specialty.*

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

Patient/Guardian Signature

Physician

Date

COMMUNICATIONS VIA ELECTRONIC TECHNOLOGY

Electronic devices have become a part of everyday life and make communication between physician, practice, and patient much easier and more efficient. I understand that Delaware Valley Plastic Surgery often communicates with patients via email and/or text messaging. While every effort is made to maintain your privacy including using encrypted email communications, no electronic communication is completely secure. For example text messages used to confirm appointments are one example of potentially non-secure electronic technology. I understand this and voluntarily accept to have communications via electronic forms including but not limited to email and text/SMS messaging. I also understand that in an emergency situation I will use voice telephone to contact the physician as the only guarantee to no delay in message transmission.

Patient/Guardian Signature

Physician

Date