MANHATTAN OCULOFACIAL PLASTIC SURGERY, P.C
BOAZ J. LISSAUER, MD
1036 PARK AVE, SUITE 1C
NEW YORK, NY 10028-0971
P: 212-717-2150 F: 212-717-2154

INSTRUCTIONS FOR HOSPITAL REGISTRATION FORMS

IF YOU CHOOSE TO FAX:

UPON COMPLETION OF FORMS A,B,C, LENOX HILL HOSPITAL FINANCIAL STATEMENT, AND CONSENT TO SURGICAL PROCEDURE, PLEASE FAX TO 1-866-231-1027

IF YOU CHOOSE TO MAIL:

SEND COMPLETED FORMS A, B, AND LENOX HILL HOSPITAL FINANCIAL STATEMENT FORMS TO:
FINANCIAL CLEARANCE CENTER
LENOX HILL HOSPITAL
210 EAST 64TH STREET
NEW YORK, NY 10131-0041

PLEASE BRING FORM C (PATIENT QUESTIONNAIRE) AND CONSENT TO SURGICAL PROCEDURE ON THE DAY OF SURGERY.

IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CONTACT ME AT THE OFFICE.

SARAH

LenoxHill Hospital

FORM A REGISTRATION

☐ 100 East 77th Street, NY, NY 10075-1850
Surgical Cases Fax to 866-219-5545

☒ 210 East 64th Street, NY, NY 10065-7471
Surgical Cases Fax to 866-231-1027

Date of Surgery: ___/___/___

Physician's Name: _____

PATIENT INFORMATION Name: Last _____ First _____

Address: Street _____ City _____ Apt # _____ State _____ Zip _____

County Of Residence: _____ Phone ( ) _____ S.S. # ___ — ___ — ____

RACE:
☐ Asian ☐ Black ☐ White
☐ Hispanic ☐ American Indian

SEX: ☐ Male ☐ Female

MARITAL STATUS:
☐ Married ☐ Widowed
☐ Single ☐ Divorced
☐ Separated

DATE OF BIRTH
Month | Day | Year

Mother's Maiden Name

Patient's Maiden Name

Place of Birth

Are you an Employee of LHH / MEETH? ☐ Yes ☐ No

Religion

Advance Directives:
☐ Yes (Provide Copy) ☐ No
Type: ☐ Healthcare Proxy
☐ Living Will
☐ Do Not Resuscitate
☐ Other: _____ Specify

Do You Carry An Organ Donors Card? ☐ Yes ☐ No

Occupation

Employer

Employer Address
Street
City State Zip

Length of Service With Current Employer: Years | Months

Employer's Phone ( )

EMPLOYMENT STATUS
☐ Employed ☐ Disabled
☐ Unemployed ☐ Retired

ACCIDENT INFORMATION IF THIS ADMISSION IS THE RESULT OF AN ACCIDENT, PLEASE COMPLETE THIS SECTION IN FULL

Type of Accident: ☐ Work Related ☐ Auto ☐ Home ☐ School ☐ Other Date of Accident: Month | Day | Year

Time of Accident: ☐ AM ☐ PM Location of Accident: Street City State Zip

PERSON RESPONSIBLE FOR FINANCIAL ARRANGEMENTS

Name of Person on Insurance Card Last First Relationship to Patient

Name Last First

Address Street Apt # City

County of Residence | Phone # ( ) | Social Security # ___ — ___ — ____

Employment Status ☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired | Sex ☐ Male ☐ Female | Birth Date

Occupation | Employer

Employer Address Street City State Zip | Phone ( ) | Ext:

PERSON TO CONTACT IN AN EMERGENCY Relationship to Patient _____

Name: Last First Address: Street City Apt # State Zip

Home Phone: ( ) Work Phone: ( ) Ext:

IF PATIENT IS 18 OR UNDER (28 IF STUDENT) ENTER FATHER/MOTHER INFORMATION BELOW
IF PATIENT IS MARRIED ENTER SPOUSE INFORMATION, OTHERWISE ENTER CLOSEST RELATIVE

LEGAL NEXT OF KIN Relationship to Patient _____ Date of Birth _____

Name: Last First Address: Street City Apt # State Zip

Home Phone: ( ) Work Phone: ( ) Ext:

MISCELLANEOUS Have you ever been an inpatient at Lenox Hill Hospital / MEETH? ☐ Yes ☐ No

If yes, under what name? _____ Dates: From: Mo Dy Yr To: Mo Dy Yr

Have you been an inpatient in another Hospital or Skilled Nursing Facility within the last 60 days? ☐ Yes ☐ No

If yes, under what name? _____ Dates: From: Mo Dy Yr To: Mo Dy Yr

Name of Institution: _____

LenoxHill Hospital

FORM B REGISTRATION

☐ 100 East 77th Street, NY, NY 10075-1850
Surgical Cases Fax to 866-219-5545

☒ 210 East 64th Street, NY, NY 10065-7471
Surgical Cases Fax to 866-231-1027

Date of Surgery: ____/____/____

Physician's Name: _____

INSURANCE INFORMATION PLEASE COMPLETE THE APPROPRIATE SECTIONS BELOW FOR BOTH PATIENT AND SPOUSE, OR BOTH PARENTS IF PATIENT IS 21 OR UNDER . . . AND ATTACH A COPY OF BOTH SIDES OF THE INSURANCE CARDS.

MEDICARE

MEDICARE HEALTH INSURANCE
SOCIAL SECURITY ACT

Name of Beneficiary

Claim Number Sex

Is Entitled To Effective Date

Hospital (Part A)

Hospital (Part B)

MEDICARE PATIENTS OR SPOUSE

ARE YOU RETIRED? ☐ YES ☐ NO
IS YOUR SPOUSE RETIRED? ☐ YES ☐ NO

DATE OF RETIREMENT PATIENT
SPOUSE

OTHER BLUE CROSS

BLUE CROSS/BLUE SHIELD OF _____ STATE

SUBSCRIBER'S NAME _____

IDENTIFICATION _____

DO YOU HAVE OTHER INSURANCE? ☐ YES ☐ NO

IF SPOUSE IS EMPLOYED, PLEASE PROVIDE HIS/HER INSURANCE INFORMATION ON THIS FORM.

OTHER INSURANCE (HMO, UNION, TRAVELERS, METROPOLITAN, ETC.)

Name on Card LAST _____ FIRST _____

Policy Number ID _____ GRP # _____

Payor ID Number _____

Group Name _____

• Employer Name _____ AS IT APPEARS ON THE CARD

Address _____

Phone _____

Insurance Company Name _____

Address _____

Phone _____

WORKERS COMP (ATTACH AUTHORIZATION FORM)

INSURANCE COMPANY NAME _____ ADDRESS _____ PHONE ( ) _____ - _____

EMPLOYER NAME _____ ADDRESS _____ PHONE ( ) _____ - _____

WCB # _____ Accident Date ____/____/____ Accident Time _____ ☐ AM ☐ PM Claim Filed: ☐ Yes ☐ No

NO FAULT (ATTACH FORM FROM INSURANCE COMPANY)

INSURANCE COMPANY NAME _____ ADDRESS _____ PHONE ( ) _____ - _____

CAR OWNER NAME _____ ADDRESS _____ PHONE ( ) _____ - _____

INSURANCE AGENT OR ATTORNEY NAME _____ PHONE ( ) _____ - _____

ACCIDENT DATE ____/____/____ Accident Time _____ ☐ AM ☐ PM POLICY NO. _____ FILE NO. _____

MEDICAID

NAME ON CARD LAST _____ FIRST _____

ID NUMBER _____

ISO # _____ ACCESS NUMBER _____ SEQ # _____

☐ **SELF PAY/UNINSURED**

FORM C

LenoxHill Hospital

☐ 100 East 77th Street, NY, NY 10075-1850
Surgical Cases Fax to 866-219-5545

☒ 210 East 64th Street, NY, NY 10065-7471
Surgical Cases Fax to 866-231-1027

PATIENT QUESTIONNAIRE

Patient Name:

Surgeon:

Planned procedure:

_____

Please list ALL PAST SURGERIES:

_____

_____

_____

ANESTHESIA problems: ☐ Yes ☐ No

If Yes, please list:

_____

Please list ALL MEDICATIONS, including DOSAGE :

_____

_____

_____

_____

_____

_____

List any ALLERGIES (medications/food/inhalant):

_____

_____

Do you smoke? ☐ Yes ☐ No

Did you previously smoke? ☐ Yes ☐ No

Packs per day:_____ for _____ years Quit_____

Do you drink alcohol? ☐ Yes ☐ No

Number of drinks per week _____

Do you use recreational drugs? ☐ Yes ☐ No

Please List _____ How often_____

Please list any non-prescription medications:
(e.g. cold tablets, vitamins)

_____

_____

Please list any HERBAL:
(e.g. Cava-Cava, Ginkgo, Ginseng, St. John's wort, Echinacea)

_____

_____

Please check any symptoms you have recently experienced:

☐ Fever / chills ☐ Weight loss

☐ Weakness ☐ Fatigue

☐ Pain (identify location):_____

Please list ALL YOUR medical conditions:

☐ Anxiety	☐ Kidney disease
☐ Arthritis	☐ Liver disease
☐ Asthma	☐ Pacemaker
☐ Bleeding problems	☐ Palpitations/irregular heart
☐ Bronchitis	☐ Pneumonia
☐ Chest pain	☐ Reflux
☐ COPD	☐ Seizure
☐ Depression	☐ Shortness of breath
☐ Diabetes	☐ Sickle cell
☐ Excessive bruising	☐ Sleep apnea
☐ Glaucoma	☐ Stroke
☐ Heart Attack	☐ TB
☐ Heat/Cold problems	☐ Thyroid disease
☐ Hiatal hernia	☐ Ulcer
☐ High blood pressure	☐ Urinary problems

Family History of Medical Conditions:

☐ Asthma	☐ Heart
☐ Cancer	☐ High blood pressure
☐ Diabetes	☐ Stroke
☐ Emphysema	☐ Other:_____

List your primary care physician:

Name:_____

Address:_____

_____

Telephone:_____

Date:_____ Patient Signature:_____

LenoxHill Hospital

100 East 77th Street, NY, NY 10075-1850
210 East 64th Street, NY, NY 10065-7471

FINANCIAL STATEMENTS FORM

INSTRUCTIONS

There are four separate statements on this form. If you have any insurance coverage such as Blue Cross, Commercial Insurance, Medicare, or if your hospital service will be for a condition as a result of a motor vehicle or employment related accident please complete sections 1, 2 and 4.

MEDICARE PATIENTS MUST ALSO SIGN # 3.

Your signature is required in each of the areas to:

1. Allow us to release information needed by your insurance carrier to pay the claim, either to you or to Lenox Hill Hospital.
2. Permit the insurance company to pay the bills we submit directly to Lenox Hill Hospital.
3. Serves the same purpose as #1 & #2 above and contains the special wording which Medicare requires in order for us to release information or receive payment from Medicare.
4. Acknowledge that you understand you are financially liable for any services we render which are not paid by insurance.

PLEASE READ THE STATEMENTS CAREFULLY AND SIGN IN EACH PLACE AS INDICATED. KEEP THE YELLOW COPY FOR YOUR RECORDS.

LenoxHill Hospital

FINANCIAL AGREEMENTS

☐ 100 East 77th Street, NY, NY 10075-1850
☒ 210 East 64th Street, NY, NY 10065-7471

PATIENT NAME (last) _____ (first) _____ (mi.) _____

MEDICAL RECORD NO. _____

1. RELEASE OF INFORMATION

I hereby authorize and direct Lenox Hill Hospital and/or any physician or organization providing medical services to release to governmental agencies, insurance carriers, or others who are, or may be, financially responsible for my hospitalization and medical care, all information needed to substantiate payment for such hospitalization and medical care, and to permit representatives thereof to examine and make copies of all records relating to my care and treatment.

DATE ___/___/___ SIGNATURE _____
PATIENT OR RESPONSIBLE PERSON

2. ASSIGNMENT OF BENEFITS

I hereby assign to Lenox Hill Hospital and/or any physician or organization providing medical services any and all benefits, including benefit of payment, to which I may be entitled from any governmental agency, insurance carrier, or others who are financially responsible for the hospitalization and medical care rendered to me or my dependant at said hospital.

DATE ___/___/___ SIGNATURE _____
PATIENT OR RESPONSIBLE PERSON

3. MEDICARE INSURANCE

I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information regarding my treatment, to release to the Social Security Administration and/or the Health Care Financing Administration or its intermediaries or carriers, any information needed for this related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare in my behalf.

DATE ___/___/___ SIGNATURE _____
PATIENT OR RESPONSIBLE PERSON

4. FINANCIAL AGREEMENT & GUARANTEE

For services rendered or to be rendered, the undersigned (jointly or severally) promise to pay to Lenox Hill Hospital, New York, New York and/or any physician or organization providing medical services the full and entire amount of any and all bills not paid by my hospitalization insurance plan, private or governmental, or combination of plans. I understand that all such bills are due and payable upon presentation; are in accordance with the posted charges of the hospital which are available upon request. Payment may be demanded at any time from either of the undersigned and failure to demand payment of the patient shall not be a prerequisite to the guarantors immediate responsibility for payment.

We agree that if all or part of the patient's hospital bill is rejected by Blue Cross, Medicare, Medicaid, Workman's Compensation, or other hospital insurance plan, payment of the balance shall be due immediately upon notice. While the patient is in the hospital, we agree to pay hospital bills rendered on a weekly basis for services not covered by the patient's insurance plan.

WE HAVE READ THIS AGREEMENT AND WE FULLY UNDERSTAND ITS NATURE AND SIGNIFICANCE. WE HAVE RETAINED A COPY OF THIS AGREEMENT.

DATE ___/___/___ SIGNATURE _____
PATIENT OR RESPONSIBLE PARTY
(PARENT IF A MINOR)

North Shore LIJ Lenox Hill Hospital
100 East 77th Street, New York, NY 10075-1850
210 East 64th Street, New York, NY 10065-7471

CONSENT TO SURGICAL PROCEDURE, INVASIVE TEST, PROCEDURE, TREATMENT and/or ANESTHESIA

I hereby authorize Dr. _____ and his/her associates or assistants to perform upon the named patient or me the following surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s):

_____

_____

_____

including such photographing, videotaping, televising or other observation of the surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s) as may be purposeful for the advancement of medical knowledge and/or education, with the understanding that my/the patient's identity will remain anonymous.

The purpose of the surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s) has/have been explained to me and I have also been informed of the expected benefits and possible complications, attendant discomforts and risks that may arise, as well as possible alternatives to proposed treatment, including no treatment. The attendant risks of no treatment have also been discussed. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.

I understand that during the course of the surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s) that unforeseen conditions may arise which necessitate procedures different from those contemplated. I, therefore, consent to the performance of additional surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s) which the above-named physician or practitioner or his/her associates or assistants may consider necessary.

I consent to the release of my social security number to the manufacturer of any device that is surgically implanted in me during my admission. I understand release of my social security number is for the purpose of helping the manufacturer locate me if there is a need to contact me with regard to the implanted medical device.

I further consent to the administration of blood transfusion(s) during surgery and during the Recovery Room period as may be considered necessary. I recognize that there are always risks to life and health associated with blood transfusion(s) and such risks have been fully explained to me. The benefits of blood transfusion(s) and alternatives to their use have also been explained to me.

I understand that the use and type of anesthesia, sedatives or analgesics which may be considered necessary will be explained to me by the Anesthesiologist before surgery or by the physician or practitioner administering the medication prior to any surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s). The risks, benefits and alternatives to their use will also be explained to me.

I understand any organs or tissues surgically removed may be examined and retained by the Hospital for medical, scientific or educational purposes and such tissues or parts may be disposed of in accordance with customary practices.

I acknowledge that no guarantees or assurances have been made to me concerning the results intended from the surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s).

I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing. I have crossed out any paragraphs or words above, which do not pertain to me.

Patient/Healthcare Agent/Guardian/Next-of-kin: _____
Signature

_____
Print Name Date/Time

Relationship (if signed by other than patient): _____

Witness: _____
Signature Print Name Date/Time

Interpreter: _____
Signature Print Name Date/Time

Physician/Practitioner Certification

I hereby certify that the nature, purpose, benefits, risks of, and alternatives to (including no treatment and attendant risks), the surgical procedure(s)/invasive test(s)/procedure(s) and/or treatment(s) and blood transfusion(s) have been explained to the patient. Any and all questions have been answered. I believe that the patient/healthcare agent/guardian/next-of-kin fully understands what has been explained.

Physician/Practitioner: _____
Signature/Title Print Name Date/Time

North Shore LIJ Lenox Hill Hospital
100 East 77th Street, New York, NY 10075-1850
210 East 64th Street, New York, NY 10065-7471

SEDATION ANALGESIA CONSENT

I hereby authorize Dr. _____ and his/her associates or designees to administer sedation analgesia to me/the patient during the performance of: (Name of Procedure(s))

_____

_____

The risks, benefits and alternatives to sedation analgesia, including withholding sedation analgesia, have been explained to me. I acknowledge that I have been given an opportunity to ask any questions I have concerning the administration of sedation analgesia and my questions have been answered fully and to my satisfaction.

Patient/Healthcare Agent/Guardian/Next-of-kin: _____
Signature

_____
Print Name Date/Time

Relationship (if signed by other than patient): _____

Witness: _____
Signature Print Name Date/Time

Interpreter: _____
Signature Print Name Date/Time

Physician/Practitioner Certification

I hereby certify that the nature, purpose, benefits, risks of, and alternatives to sedation analgesia, including no sedation analgesia have been explained to the patient. Any and all questions have been answered. I believe that the patient/healthcare agent/guardian/next-of-kin fully understands what has been explained.

Physician/Practitioner: _____
Signature/Title Print Name Date/Time

UNAUTHORIZED DEPARTURE (AGAINST MEDICAL ADVICE) DOCUMENTATION

I acknowledge that _____ (Name of Patient) is leaving the Hospital against the advice of Dr. _____ and his/her associates or assistants. I have been advised of the potential risks of leaving against medical advice. I have been provided with an opportunity to ask questions about my/the patient's care and the potential consequences of my/the patient's actions. All of my questions have been answered. I agree not to hold the Hospital, its agents, servants and employees and Dr. _____ responsible for any harm or injury that may result from my action.

Patient/Healthcare Agent/Guardian/Next-of-kin: _____
Signature

_____
Print Name Date/Time

Relationship (if signed by other than patient): _____

Witness: _____
Signature Print Name Date/Time

Interpreter: _____
Signature Print Name Date/Time

Physician/Practitioner Certification

I hereby certify that the nature, purpose, benefits, risks of, and alternatives to the patient leaving the Hospital against medical advice have been explained to the patient. Any and all questions have been answered. I believe that the patient/healthcare agent/guardian/next-of-kin fully understands what has been explained.

Physician/Practitioner: _____
Signature/Title Print Name Date/Time