COLUMBIA UNIVERSITY MEDICAL CENTER

DEPARTMENT OF SURGERY

Registration Form

FOR OFFICE USE ONLY	
MRN:	Div:

Appointment w/:	Today's Date:

Patient Information:

Last Name		First Name		M
Date of Birth	Age	Sex	Marital Status	
Street Address		City/State		Zip Code
Home Phone # ( ) -	Mobile # ( ) -	Work# ( ) -	Email	
Mother's First Name:		Father's First Name:		

This is for medical record purposes only.

Employer Information:

Occupation	Employer's Name/Address

Emergency Contact Information:

Name	Relationship	Phone # ( ) -

Referral Source (From whom/how did you hear about this Provider?):

Name/Type: ☐ Physician ☐ Family or Friend ☐ Website/ Search ☐ Advertisement ☐ Other _____

Primary Care Physician	Address	Phone# ( ) -
Cardiologist	Address	Phone# ( ) -
Physician (Other) _____	Address	Phone # ( ) -

Insurance Information:

Patient Relationship to Guarantor (circle one) **SELF** **SPOUSE** **DEPENDENT CHILD** **STUDENT**	
Primary Insurance	Policy #
Guarantor Name	DOB
Secondary Insurance	Policy #
Guarantor Name	DOB

Pharmacy Information:

Circle One: **Retail Pharmacy** **Mail-Order Pharmacy**	Name
Address	Phone # ( ) -

Authorization for Treatment and Release of Information

I hereby authorize and direct the above named clinical practice having treated me, to release to governmental agencies, insurance carriers, or others financially liable for my medical care, all information needed to substantiate payment for such medical care; and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. I furthermore authorize the treating physician/pracitce to take and use my photos for insurance predetermination and educational purposes.

Financial Responsibility (For Provider Indicated in the "Appointment w/" section of this form)

Medicare Patients: I request that payment of authorized health insurance benefits be made to me or on my behalf to the provider(s) for any services furnished to me by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration, and its agents, any information needed to determine these benefits or the benefits payable for related services.

Commercial/Other Insurance: I hereby authorize direct payment of surgical/medical benefits to my provider, for services rendered by him/her in person or under his/her supervision if I have not paid in advance. I understand that I am financially responsibly for all services. Additionally, I understand that all bills are my responsibility if not paid by the carrier.

Out of Network: I understand that the doctor is a **non-participating provider** of my insurance and therefore I will be responsible for any balances on this account.

Self-Pay: I agree to pay at the time the services are rendered.

I verify the accuracy of the above information and authorize treatment and release of information as indicated on this form.	**Patient (Guardian) Signature** X	**Date**
I understand and agree to terms of my financial responsibility as indicated on this form.	**Patient (Guardian) Signature** X	**Date**

COLUMBIA UNIVERSITY MEDICAL CENTER

CROWN Adult Intake Form Section 1

LAST NAME: _____ FIRST NAME: _____ dob: _____

What is the reason for your visit today? _____

Do you have any allergies to medications or other substances? Yes___No___ If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis). _____

_____ Height_____ Weight_____

Please list ALL of your current medications below (use back of page if you need more room)

Medication Name	Dose	When do you take it?	Approximate start date of medication

MEDICAL HISTORY: HAVE YOU EVER HAD (been diagnosed or treated for) ANY OF THE FOLLOWING (if yes, describe):

Heart Disorder Yes No __ _____

Cancer Yes No __ _____

Diabetes Yes No __ _____

Blood Pressure Disorder Yes No __ _____

Thyroid Disorder Yes No __ _____

Lung Disorder Yes No __ _____

Stomach/Intestinal Disorder Yes No __ _____

Skin Disorder Yes No __ _____

MEDICAL HISTORY Continued:

Clotting Disorder Yes___No___ _____

Eye Disorder Yes___No___ _____

Psychiatric Disorder Yes___No___ _____

Urinary/Kidney Disorder Yes___No___ _____

Liver Disorder Yes___No___ _____

Orthopedic Disorder Yes___No___ _____

Cholesterol Disorder Yes___No___ _____

Neurologic Disorder Yes___No___ _____

Other Yes___No___

COLUMBIA UNIVERSITY MEDICAL CENTER

CROWN Adult Intake Form Section 1

LAST NAME:_____ FIRST NAME:_____ dob:_____

FAMILY HISTORY: *Please indicate any major conditions/illnesses that your family members have had.*

RELATIVE CONDITION & DESCRIPTION LIVING (Y/N) IF DECEASED, AT WHAT AGE?

Mother:_____

Father:_____

Other:_____

SURGICAL HISTORY: List any surgeries you have had and the approximate date:

_____

_____

Have you had a blood transfusion Yes__No__? If yes, when?_____

SOCIAL HISTORY:

Occupation: _____Marital Status:_____Children? Yes__No__ Their ages? _____

Do you exercise regularly? Yes__No__ Describe your exercise routine:_____

Do you have pets in your home?Yes__No__ Describe:_____Health Care Proxy_____

Smoking: Currently? Yes__No__ Previously? Yes__No__ Years Smoked_____ Packs per day_____

Other tobacco or substance_____Date stopped_____

Are/were you exposed to 2nd hand smoke at home or work? Yes__No__ , If "Yes," explain_____

Other substances: Alcohol? Yes__No__ Recreational Drugs? Yes__No__

Describe use_____

Patient Signature_____**Date**_____

FOR OFFICE USE ONLY:

CROWN-05-05-09 intake

The following sections were entered into CROWN by (sign initials next to the section(s) you entered):

*All*_____*Problems*_____*Allergies*_____*Medical Hx*_____

Surgical Hx _____*Family Hx*_____*Social History*_____

Physician Signature_____**Date**_____

COLUMBIA UNIVERSITY
MEDICAL CENTER

Health Insurance Portability and Accountability Act (HIPAA)
HIPAA Compliance/Columbia University Medical Center
601 West 168th Street, Apt. #22, 2nd Floor
New York, NY 10032/ T(212) 342-0059 F(212)342-5173
http://www.cumc.columbia.edu/hipaa/

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

DATE:_____

I acknowledge that I was provided with a copy of the Columbia University Medical Center Notice of Privacy Practices.

_____ _____
Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below

_____ _____
Personal Representative (Print) Personal Representative's Signature

_____
Relationship

For Columbia University Medical Center use only.

Complete this section if this form is not signed and dated by the patient or patient's representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Columbia University Medical Center's Notice of Privacy Practices but was unable to for the following reason:

- ☐ Patient refused to sign
- ☐ Patient unable to sign
- ☐ Other _____

_____ _____
Employee Name Date

This form should be placed in the patient's medical record

Revised October 2007

New York Presbyterian
Division of Plastic Surgery
161 Fort Washington Avenue, New York, NY 10032
Office 212-305-9612
Fax 212-305-9626

Medication List (Please Print Legibly)

Medication	Dosage	# Times a day	Reason for Medication (e.g. High Blood Pressure)

Please fill out medications, dosages prescribed with, and how many times a day. Also include herbs, Vitamins, Minerals, and any other Supplements that you are currently taking.

Patient name (print) _____ Date_____

Signature _____