

Belmont Aesthetic and Reconstructive Plastic Surgery

Jules A Feledy, Jr., M.D.
American Board of Plastic Surgery, Diplomate

Joseph Michaels V, M.D.

Patient Medical History

Last Name _____ First Name _____ Age _____ Date of Birth ____/____/____ Female Male

Address _____

SSN _____ - _____ - _____ Email _____ City _____ State _____ Zip code _____

Home Phone # (_____) _____ Work Phone # (_____) _____ Cell Phone # (_____) _____

Best time to reach? a.m. p.m. Best number to use: Home Cell Work

Height _____ Weight _____ Primary Language: English Spanish Other _____

Have you previously ever been treated by Dr. Feledy or Dr. Michaels? Yes No If yes when and where? _____

Primary Care Physician _____ Date Last Seen _____

Address of Physician _____

Phone of Physician _____

Oncologist _____ Date Last Seen _____

Surgeon _____ Other Physicians _____

Medical Insurance _____ Policy # _____ Group # _____

Do you have an Advanced Directive (Living Will)? Yes No If yes, copy should be on file in your medical record. If not available, who is legal representative: Name, phone number & address: _____

Are you currently residing in a nursing facility? Yes No If yes, which facility? _____

How did you hear about us? Doctor _____ Internet Yellow pages Direct Mail Friend Family

Other (please specify) _____

Present Illness / Condition
What type of exam/consultation are you here for: List Recent ER Visits: _____ Recent Hospitalizations: _____
What diagnostic tests, related to this problem, have you had? If applicable, please remember to bring copies of any pertinent reports & x-ray films. List facility name & date(s) performed.
Symptom(s) Describe: Date(s) of onset: Location (Where on body symptom occurs):

Health History –Do you now have OR have you ever been treated for the following? <i>Circle all that apply.</i>			
Cardiac / Heart Disease <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Chest Pain <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood pressure <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Pacemaker / ICD <input type="checkbox"/> Pulmonary Hypertension <input type="checkbox"/> Rheumatic Heart <input type="checkbox"/> Rhythm disturbances Specify: <input type="checkbox"/> None	Cancer or Tumor <input type="checkbox"/> Type _____ <input type="checkbox"/> Chemo _____ <input type="checkbox"/> Radiation _____ <input type="checkbox"/> Skin - Basal / Squamous other _____ <input type="checkbox"/> Breast Endocrine <input type="checkbox"/> Diabetes Circle : Diet / Pill / Insulin /Pump <input type="checkbox"/> Thyroid Problems / Goiter <input type="checkbox"/> Adrenal disease <input type="checkbox"/> None	Respiratory <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Emphysema / COPD <input type="checkbox"/> Hoarseness <input type="checkbox"/> Pneumonia <input type="checkbox"/> Sleep Apnea CPAP - Y / N? <input type="checkbox"/> Snoring <input type="checkbox"/> History of smoking <input type="checkbox"/> None	Neurological/Mental Health <input type="checkbox"/> Stroke <input type="checkbox"/> Stroke Mini (TIA) <input type="checkbox"/> Epilepsy or Seizures Disorders <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Chemical dependency <input type="checkbox"/> Myasthenia Gravis <input type="checkbox"/> Depression / Anxiety <input type="checkbox"/> Emotional Illness <input type="checkbox"/> Claustrophobia <input type="checkbox"/> Panic attack <input type="checkbox"/> Learning Disabilities <input type="checkbox"/> None

Health History –Do you now have OR have you ever been treated for the following? *Circle all that apply. (continue)*

Bleeding Circulation <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding tendency <input type="checkbox"/> Blood clots <input type="checkbox"/> Poor circulation <input type="checkbox"/> Sickle Cell <input type="checkbox"/> None	Genitourinary <input type="checkbox"/> Kidney disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Prostate/testicle problem <input type="checkbox"/> Urinary Tract Infection <input type="checkbox"/> Difficulty urinating <input type="checkbox"/> None	Gastrointestinal <input type="checkbox"/> Hernia <input type="checkbox"/> Gallbladder <input type="checkbox"/> Gastric Reflux <input type="checkbox"/> Intestinal Blockage <input type="checkbox"/> Liver Disease <input type="checkbox"/> Intestinal or Gastric Ulcers <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> None	Musculoskeletal <input type="checkbox"/> Arthritis <input type="checkbox"/> Gout <input type="checkbox"/> Limited movement <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Back / neck Problems <input type="checkbox"/> Polio <input type="checkbox"/> None
Hearing & Vision <input type="checkbox"/> Hearing loss <input type="checkbox"/> Hearing Aide <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataract <input type="checkbox"/> None	Implantable Devices <input type="checkbox"/> Dialysis Port / Pump <input type="checkbox"/> Other Ports/Pumps <input type="checkbox"/> Pacemaker/ICD <input type="checkbox"/> Other (list) Important! Bring implant card with you.	Infectious Diseases <input type="checkbox"/> Recent Mono <input type="checkbox"/> HIV <input type="checkbox"/> Hepatitis <input type="checkbox"/> MRSA <input type="checkbox"/> TB - Tuberculosis <input type="checkbox"/> VRE <input type="checkbox"/> C Diff <input type="checkbox"/> None	Skin <input type="checkbox"/> Rashes <input type="checkbox"/> Sore/Open areas <input type="checkbox"/> Skin Ulcer Where? _____ <input type="checkbox"/> None

Have you been hospitalized for any of the above conditions?

Briefly Explain: _____

Date(s)? _____

Hospital Name, City State: _____

Surgical History - Check all that apply & Specify Date(s)

<input type="checkbox"/> No prior surgery <input type="checkbox"/> Angioplasty <input type="checkbox"/> Appendectomy <input type="checkbox"/> Arthroscopy <input type="checkbox"/> Breast Biopsy <input type="checkbox"/> Heart Bypass	<input type="checkbox"/> Cataract <input type="checkbox"/> Colon / Intestinal <input type="checkbox"/> D & C <input type="checkbox"/> Gallbladder <input type="checkbox"/> Heart Catheter <input type="checkbox"/> Heart Valve replaced	<input type="checkbox"/> Hemorrhoidectomy <input type="checkbox"/> Hernia <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Kidney removal <input type="checkbox"/> Mastectomy L R <input type="checkbox"/> Pacemaker	<input type="checkbox"/> Prostate <input type="checkbox"/> Spine (Back/Neck) <input type="checkbox"/> Splenectomy <input type="checkbox"/> Tonsils & Adenoids <input type="checkbox"/> Total Hip L R <input type="checkbox"/> Total Knee L R	<input type="checkbox"/> Tubal Ligation List any other: _____ _____ Date(s) _____ _____
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Do you have any ALLERGIES?		Specify (List each)	Reaction(s) – Be specific
Latex	<input type="checkbox"/> Yes <input type="checkbox"/> No		Circle: hives, wheezing, itching From: rubber, sneakers, or balloons
Drug(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Food	<input type="checkbox"/> Yes <input type="checkbox"/> No	Circle: banana, kiwi, avocado, tomato, seafood	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	Circle: Adhesive	

Are you on any MEDICATIONS?		Specify (List each or Circle). List Medication & Dose
Aspirin / Baby Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Antidepressants	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Blood pressure pills	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Blood thinner	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Eye drops	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fluid (water) pills	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart pills	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Herbal remedies/ Vitamins	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Inhalers	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Prednisone/Steroids in last 3mo?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you on Other Medications ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Family History (Close blood relatives): Check all that apply

<input type="checkbox"/> Bleeding/Clotting Problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Cancer: _____	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Neurological	<input type="checkbox"/> Tuberculosis

If yes to any above, Specify relationship:

Anesthesia History	Ye	No	Explain (<i>specify: nausea, vomiting, other</i>)
Have you ever had anesthesia?			
Have you ever had a problem with anesthesia including malignant hyperthermia or difficult intubation?			
Has any member of your family had a problem with anesthesia?			
Loose, capped or broken teeth: bridges or dentures?			
Trouble opening mouth or jaw clicking?			
Do you exercise regularly?			If yes: low / moderate / active
Do you have shortness of breath after walking up 2 flights of stairs?			
Do you smoke?			#packs per day _____ # years _____
Are you an ex-smoker? When stopped?			
Do you drink alcoholic beverages?			How often _____ how much _____
Do you use any street drugs?			
Have you ever had a blood transfusion?			If "yes", what year(s)?
Do you have objections to receiving blood transfusions?			
Do you have problems with chronic pain?			
Any religious/cultural practices we should know about?			
<i>Females Only</i> – Is there any chance you could be pregnant?			Last Menstrual Period?

Additional Notes:

Patient Signature _____ Date _____ If Legal Guardian, Relationship to Patient _____

5530 Wisconsin Avenue, Suite 1455
Chevy Chase, MD 20815
301.654.5666

7625 Wisconsin Ave, Suite 101
Bethesda, MD 20814
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2765 Jeff Davis Highway, Suite 201
Stafford, VA 22554
540.891.0040

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Patient Registration

PLEASE PRINT

Date

Patient Information				
First Name		Last Name		Middle Initial
Address		City, State		Zip Code
Home Phone		Date of Birth		Sex M F
Marital Status		Social Security		
Employer		Work Phone		Cell Phone
Employer Address		City, State		Zip Code
Referring Physician		Primary Care Physician		
Pharmacy Name		Pharmacy Location		
Emergency Contact				
First Name		Last Name		Middle Initial
Address		City, State		Zip Code
Home Phone	Alternate Phone: work/cell		Relationship to Patient	
Employer		Employer Address		
Responsible Party Information (if different from Patient)				
First Name		Last Name		Middle Initial
Address		City, State		Zip Code
Home Phone		Alternate Phone: work/cell		Relationship to Patient
Employer		Employer Address		
Insurance Information				
Primary Insurance		Secondary Insurance		
Subscriber Name		Subscriber DOB	Subscriber Name	
			Subscriber DOB	
Policy Number		Policy Number		
SSN		SSN		
Relationship to Patient		Relationship to Patient		

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To All Patients:

We ask that all patients pay for their office visit at the time of service. Unless you have made prior arrangements made through a payment plan agreement or we participate with your insurance plan. We ask for 24 hr cancellation of scheduled appointments, or a \$50.00 fee will be billed to the patient.

RETURNED CHECK FEE:

I understand and agree that if any payment made by me or on my behalf by check is returned from the financial institution as unpaid, in addition to the original sum, I am responsible and agree to pay a \$50.00 returned check fee. A copy of this agreement may be used in place of an original.

ASSIGNMENT OF BENEFITS:

I certify that the insurance information provided with regard to my insurance coverage is correct. I further authorize the release of any information necessary, including medical information for this or any claims generated from this office for covered services provided to my insurance carrier. A copy of this authorization may be used in place of the original. I hereby assign the benefits payable for covered services to be paid directly to "Belmont Aesthetic and Reconstructive Plastic Surgery PLLC".

MEDICARE PATIENTS:

I authorize the holder of medical or other information about me to release to the Social Security Administration of its intermediaries of carriers any information for all Medicare claims. I assign the benefits payable for covered services to "Belmont Aesthetic and Reconstructive Plastic Surgery PLLC"

GUARANTEE OF PAYMENT:

I understand and agree that I am responsible for payment of all professional services rendered now and in the future by this practice. If I am insured and this practice is a participating provider with my insurance, I am financially responsible for all payments my insurance company identifies as my responsibility. I agree to pay all balances due in a timely manner (within 30 days). A copy of this agreement may be used in place of an original. If the practice is not a participating provider, I authorize payment of medical benefits from all insurance reimbursements to Belmont Aesthetic and Reconstructive Plastic Surgery.

COLLECTION FEE:

If I do not pay all balances owed by me in a timely manner (within 30 days), the undersigned hereby agrees to pay 18% interest per annum on said balances to accrue from the date of professional services were originally rendered: plus attorneys fees which are hereby stipulated to be 33 1/3 % of such outstanding balance whether suit is filed or not, plus court costs. If the undersigned fails to pay promptly for the services rendered, the undersigned authorizes the release by or to any credit reporting agencies of personal credit information on the undersigned and further agrees to pay all costs of obtaining credit information and/or locating the undersigned as may be necessary,

In the event prompt payment is not made by the undersigned, the undersigned understands that personal and financial records concerning these professional services will be released to the provider's attorney for collection. The attorney will act as the provider's "Business Associate" in compliance with federal "HIPPA" regulations. A copy of this agreement may be used in place of an original.

Signature of Patient or Responsible Party

Date

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PATIENT PRIVACY AND CONSENT

I, _____, hereby consent to the use or disclosure of my protected health information by the practice of Jules A. Feledy, Jr., M.D. and Joseph Michaels V, M.D., hereinafter referred to as ("Belmont Aesthetic and Reconstructive Plastic Surgery"), for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by the Practice may be conditioned upon my consent as evidenced by my signature on this document.

I understand that payment for procedures that are aesthetic or cosmetic in nature are my sole responsibility and will not be billed to any third party. I understand that payment for such procedures may be requested in advance of any treatment. I understand there are no warranties, implied or otherwise, to the outcomes of any treatments or procedure.

I have been offered, read and/or understand the Practice's *Notice of Privacy Practices*, which has been offered to me by the practice, prior to signing this document. I understand that patient privacy rights and disclosure varies state by state.

I also understand that the *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations. This *Notice of Privacy Practices* also describes my rights and the practice's duties with respect to my protected health information. The *Notice of Privacy Practices* for the Practice is available at the offices:

Practice: _____ Belmont Aesthetic and Reconstructive Plastic Surgery

I wish to be contacted in the following manner (check all that apply)

<input type="checkbox"/> Home Phone: _____	<input type="checkbox"/> OK to leave message at work
<input type="checkbox"/> OK to use fax#: _____	<input type="checkbox"/> Cell Phone: _____
<input type="checkbox"/> OK to leave a message with detailed information	<input type="checkbox"/> OK to leave message on cell
<input type="checkbox"/> Work Phone _____	<input type="checkbox"/> Other: _____

Terms of the *Notice of Privacy Practices* may change. If changes are made, I may obtain a revised *Notice of Privacy Practices* by: calling the offices of the practice requesting a revised copy to be sent in the mail, or by requesting one at the time of my next appointment.

Signature of Patient or Personal Representative if the Patient is a Minor

Date

Printed Name of Patient or Personal Representative

Relationship of Personal Representative to the Patient

Signature of Practice Representative and Witness

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PHOTOGRAPHIC RELEASE AND CONSENT

I, _____ agree that Jules, A. Feledy, Jr., M.D. and Joseph Michaels V, M.D. or designated representatives or the practice may take and use preoperative and postoperative photographs of my person for confidential clinical record purposes, and that such photographs shall remain the property of Belmont Aesthetic and Reconstructive Plastic Surgery.

Patient Signature

Date

I fully and specifically grant my permission for the use of photographs, videotapes or case information for the following additional purposes as indicated by my initials below. As a result of this use I understand that these photographs, videotapes or case information may appear in other related, updated or reprinted formats at any concurrent or future occasion. I understand that such consent is strictly on a voluntary basis. I understand a copy of this consent may be supplied with the images to any third party wherein they may be published or presented. I understand that some photographs may, by their representation make me identifiable in appearance to others. I authorize Jules A. Feledy, Jr., M.D. and/or Joseph Michaels V, M.D. to use my photographs, videotapes, and case information in the following educational and scientific settings that I have initialed:

- _____ My surgeon's office patient education materials
- _____ My surgeon's file of pre- and postoperative patient photographs available to prospective patients for viewing in the office
- _____ Newspaper and magazine articles in which my surgeon participates
- _____ Television programs in which my surgeon participates
- _____ My surgeon's personal web site or web page
- _____ Lectures and multimedia presentations given by my surgeon for the general public

I also authorize Dr. Jules A Feledy, Jr.'s professional association, the not-for-profit **American Society for Aesthetic Plastic Surgery**, to use my photographs and case information in fulfilling its mission of public education, in the settings that I have initialed:

- _____ Patient education brochures available for purchase
- _____ Educational video tapes available for purchase
- _____ Lectures and slide presentations available for purchase
- _____ Television programs about plastic surgery
- _____ Case studies presented on the Society's web site at www.surgery.org

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

Relationship of Personal Representative to the Patient

Signature of Practice Representative and Witness