

Dr. Samieh Sam Rizk, M.D., F.A.C.S
Manhattan Facial Plastic Surgery, P.L.L.C.
Director
1040 Park Avenue
New York, N.Y. 10028

Name: _____ Date of Birth: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Age: _____ Sex: M: ___ F: ___ Student? FT: ___ PT: ___
Cell Phone #: _____ Email Address: _____
Marital Status: Married: ___ Single: ___ Widowed: ___ Divorced: ___
Employer's Name: _____ Work Phone #: _____
Employer's Address: _____ City: _____ State: ___ Zip: _____
Social Security #: ___ - ___ - ___ Allergies To Medicine: _____
Primary Care Doctor (first and last name): _____ Address: _____
Referring physician: _____ Referral Phone #: _____
Name of Dermatologist: _____ Phone#: _____

Parent / Guardian / Spouse Information

Name: _____ Date of Birth: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Home Phone #: _____ Work #: _____ SS #: ___ - ___ - ___

Primary Insurance

Name of Insurance: _____ ID #: _____
Insured's Name: _____ Group #: _____
Insured's Date of Birth: _____ Insured's SS#: ___ - ___ - ___
Employer's Name: _____

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, _____, understand that I am using my out-of-network benefits for services provided to me by Dr. Samieh Rizk and/or Park Avenue Facial Surgery, and for that reason I am primarily responsible for payment of services received. I authorize payments of medical benefits to Samieh Rizk, M.D., Manhattan Facial Plastic Surgery and Park Avenue Facial Surgery (each hereinafter a "Provider" and collectively, "Provider") for any services furnished to me by the Provider(s). In exchange for not having to pay in advance for those services (or portion of services) that I am receiving which are, or may be covered by my out-of-network benefits, I agree to forward Provider(s) all checks and explanation of benefits that I receive from any of my insurance companies related to services that I have received from Provider(s) within five(5) days of receiving them, and further agree that if I fail to forward any such payment, I will be responsible for payment of the amount I receive from my insurance companies for such services, plus interest of 15% per year calculated on a daily basis at a rate of .416%, payable beginning five (5) **days** from the date that I received such payment from my insurance companies, plus all attorney's fees and cost incurred by the Provider(s) for collection of such amount(s) from me.

Patient, Parent, Or Guardian Signature (if child is under 18 years old)

Date

Health Questionnaire

Name: _____

Date: _____

Reason for today's visit: _____

1. Have you suffered from?

Yes No

Heart Disease	_____	_____
High Blood Pressure	_____	_____
Heart Attack	_____	_____
Emphysema	_____	_____
Asthma	_____	_____
Blood Disease	_____	_____
Kidney Disease	_____	_____
Glaucoma	_____	_____
Diabetes	_____	_____
Jaundice/Hepatitis	_____	_____
Cancer	_____	_____
Anemia	_____	_____
Easy Bruising	_____	_____
Facial Trauma	_____	_____
Dry Eyes	_____	_____
Eating Disorder	_____	_____
Elaborate as needed:	_____	

2. Do you take?

St. John's Wort	_____	_____
Aspirin	_____	_____
Ginko	_____	_____
Vitamin E	_____	_____

3. Have you have ever taken?

Fen Fen	_____	_____
Accutaine	_____	_____

4. What medications do you use?

5. What medication are you allergic to?

6. Do you have any other medical problems?

7. Have you ever been hospitalized?

yes ___ no ___ please describe:

8. Have you ever had cosmetic surgery?

Yes ___ no ___ please describe:

9. Have you ever had any other surgery?

Yes ___ no ___ please describe:

10. Have you ever had any of the following habits? Yes ___ no ___

smoking Frequency _____

Alcohol Frequency _____

Recreational Drugs Frequency _____

11. Do you have any caps, crowns, bridges, or loose teeth?

12. Are you currently undergoing dental work? _____

13. How did you hear of our office?

___ Google ___ Ask.com

___ Yahoo ___ Facebook

___ AOL ___ Makemeheal.com

___ Msn/Bing ___ Other Website

___ Friend/Family ___ Physician
