

PATIENT REGISTRATION

DATE _____ FAMILY/REFERRING DR. _____

PATIENT NAME _____ BIRTH DATE ____ / ____ / ____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL _____ DRIVERS LICENSE _____

PATIENT S.S. # _____ PHONE _____ AGE _____

SEX M F MARITAL STATUS S M W D Cell Phone _____

PATIENT EMPLOYER & ADDRESS _____

EMPLOYER PHONE _____

REASON FOR VISIT _____ IS VISIT DUE TO AN INJURY YES NO

REFERRED BY WHOM _____

SPOUSE OR NEAREST RELATIVE _____ PHONE _____

ADDRESS _____ RELATIONSHIP _____

RESPONSIBLE PERSON NAME _____ S.S. # _____

ADDRESS _____

PHONE (H) _____ (W) _____ RELATIONSHIP _____

EMPLOYER & ADDRESS _____

INSURANCE INFORMATION

PRIMARY CARRIER _____ Card Holder Name _____

ADDRESS _____ Card Holder Date of Birth _____

ID # _____ GROUP # _____ PLAN _____

SECONDARY CARRIER _____ Card Holder Name _____

ADDRESS _____ Card Holder Date of Birth _____

ID # _____ GROUP # _____ PLAN _____

I HEREBY AUTHORIZE DR. PECK, AND WHERE APPLICABLE, ESSEX SURGICAL, LLC, AND /OR THE ANESTHESIOLOGIST TO RELEASE ANY INFORMATION REGARDING SERVICES RENDERED AND ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO FILE INSURANCE. I ALSO AUTHORIZE AND DIRECT PAYMENT FOR BENEFITS DUE ME FOR THE SERVICES RENDERED BY THE PREVIOUSLY NAMED PARTIES TO BE MADE TO HIM/THEM REGARDLESS OF MY INSURANCE BENEFITS. PHOTOCOPIES OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR THE FEES FOR SERVICES RENDERED. OUTSIDE LABORATORY FEES ARE THE PATIENTS RESPONSIBILITY. WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS. THIS MAY INCLUDE FAXING INFORMATION FOR HEALTHCARE PURPOSES AND BILLING, AS WELL AS LEAVING MESSAGES FOR APPOINTMENTS AND HEALTH CARE (PRE/POST OPERATIVE CALLS ARE INCLUDED).

NAME _____ DATE _____

PATIENT SIGNATURE/RESPONSIBLE PERSON

ALLERGIES, ILLNESSES AND MEDICAL PROBLEMS

YOUR NAME _____ DATE _____

	YES	NO	EFFECT		YES	NO	EFFECT
PENICILLIN	<input type="checkbox"/>	<input type="checkbox"/>	_____	TAPE	<input type="checkbox"/>	<input type="checkbox"/>	_____
OTHER MEDICATION	<input type="checkbox"/>	<input type="checkbox"/>	_____	HAY FEVER	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	FOOD	<input type="checkbox"/>	<input type="checkbox"/>	_____
IODINE	<input type="checkbox"/>	<input type="checkbox"/>	_____	SHELL FOOD	<input type="checkbox"/>	<input type="checkbox"/>	_____
CONTACT ALLERGY	<input type="checkbox"/>	<input type="checkbox"/>	_____	LATEX	<input type="checkbox"/>	<input type="checkbox"/>	_____

EXPLAIN ALLERGIC EFFECTS: _____
 DATE OF LAST TETANUS SHOT: _____

ILLNESS & MEDICAL PROBLEMS:

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	BRONCHITIS
<input type="checkbox"/>	<input type="checkbox"/>	HEART ATTACK	<input type="checkbox"/>	<input type="checkbox"/>	EMPHYSEMA
<input type="checkbox"/>	<input type="checkbox"/>	HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	PNEUMONIA
<input type="checkbox"/>	<input type="checkbox"/>	OTHER HEART PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS
<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	ANESTHESIA PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	DIZZY SPELLS	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH ULCER
<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	COLITIS
<input type="checkbox"/>	<input type="checkbox"/>	OTHER EYE TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	DIVERTICULOSIS
<input type="checkbox"/>	<input type="checkbox"/>	EAR TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS
<input type="checkbox"/>	<input type="checkbox"/>	SINUS TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	MONONUCLEOSIS
<input type="checkbox"/>	<input type="checkbox"/>	DEAF OR HEARING IMP.	<input type="checkbox"/>	<input type="checkbox"/>	GALL BLADDER TROUBLE
<input type="checkbox"/>	<input type="checkbox"/>	NOSE BLEEDS	<input type="checkbox"/>	<input type="checkbox"/>	STROKE
<input type="checkbox"/>	<input type="checkbox"/>	NOSE OBSTRUCTION	<input type="checkbox"/>	<input type="checkbox"/>	SLEEP APNEA/DISORDERS
<input type="checkbox"/>	<input type="checkbox"/>	SWELLING IN NECK	<input type="checkbox"/>	<input type="checkbox"/>	CONVULSIONS/SEIZURES
<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	HEALING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY / BLADDER PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	HERNIAS	<input type="checkbox"/>	<input type="checkbox"/>	VARICOSE VEINS
<input type="checkbox"/>	<input type="checkbox"/>	LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	BLEED EASILY
<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	EYE PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	BRUISE EASILY	<input type="checkbox"/>	<input type="checkbox"/>	PARALYSIS
<input type="checkbox"/>	<input type="checkbox"/>	BLEEDING DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	LUNG PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	ANKLE SWELL			

MENTAL / NEUROLOGICAL CONDITION:
 EXPLAIN: _____

CANCER:
 YEAR / TYPE: _____

HAVE YOU HAD A MOLE SCREENING?
 DATE: _____

DO YOU HAVE ANY MOLES / BEAUTY MARKS WHICH ARE IREGULAR, MULTI-COLORED, OR HAVE CHANGED?

WOMEN ONLY

<input type="checkbox"/>	<input type="checkbox"/>	TENDER BREASTS	<input type="checkbox"/>	<input type="checkbox"/>	LUMPS OR RECENT SIZE/COLOR CHANGE
<input type="checkbox"/>	<input type="checkbox"/>	FIBROCYSTIC DISEASE			PREVIOUS MAMMOGRAM YEAR: _____
<input type="checkbox"/>	<input type="checkbox"/>	MENSTRUAL PROBLEM			LAST MENSTRUAL PERIOD: _____
<input type="checkbox"/>	<input type="checkbox"/>	WERE YOUR CHILDREN BREAST FED			NUMBER OF CHILDREN: _____
<input type="checkbox"/>	<input type="checkbox"/>	DO YOU PLAN TO HAVE CHILDREN?			

HAVE ANY OF THE ABOVE CONDITIONS APPEARED IN YOUR IMMEDIATE FAMILY? IF SO, SPECIFY:

MEDICAL HISTORY

YOUR NAME _____ **WEIGHT** _____ **HEIGHT** _____

SURGERY (OPERATIONS):

1. _____
2. _____
3. _____
4. _____

ADMISSIONS TO HOSPITALS:

1. _____
2. _____
3. _____
4. _____
5. _____

MEDICATIONS (ANY DRUG OR MEDICATION) YOU TAKE NOW:

1. _____
2. _____
3. _____
4. _____

CONSUMPTION OF THE FOLLOWING:

Aspirin _____	Amount Daily _____	Amount Weekly _____
Alcohol _____	Amount Daily _____	Amount Weekly _____
Tobacco _____	Amount Daily _____	Amount Weekly _____

**BLEEDING PROBLEMS: (WITH CUTS? TOOTH EXTRACTIONS? PREGNANCY? SURGERY?)
EXPLAIN:**

**DIFFICULTIES WITH LOCAL OR GENERAL ANESTHESIA:
EXPLAIN:**

**FAMILY HISTORY OR CONDITIONS UNDER TREATMENT BY A PHYSICIAN:
EXPLAIN:**

FAMILY HISTORY: ANY FAMILY HISTORY OF MEDICAL PROBLEMS OR ILLNESS?

Mother _____	Father _____
_____	_____
Sister _____	Brother _____
_____	_____

PECK CENTER, INC./ESSEX SURGICAL, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse to sign this acknowledgement)

I, _____ have received a copy of this office's Notice of Privacy Practices/Patient Rights in advance of my date of service.

Please Print Name

Signature

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Privacy Practices, but acknowledgement could not be obtained because,

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

**GEORGE C. PECK, JR., MD
THE PECK CENTER, INC/ESSEX SURGICAL, LLC**

PHOTOGRAPHIC RELEASE AND CONSENT

I understand and accept that I may be recognized from my likeness or case history. Nevertheless, I authorize my plastic surgeon to use my photographs, videotapes, and/or case information in the following, educational, scientific, and/or commercial settings that I have checked:

- Lectures and multi-media presentations for an audience of medical professionals but where members of the press may be present.**
- Medical, surgical, and scientific journal articles.**
- My surgeon's office patient education materials; my surgeon's file of pre- and post-operative patient photographs available to my prospective patients for viewing in my office.**
- Newspaper and magazine articles in which my surgeon participates; television programs in which my surgeon participates; my surgeon's personal website or web page; lectures and multi-media presentations given by my surgeon for the general public, and for marketing my surgeons practice, such as, but not limited to, posting my review.**

By signing below, I understand all of the above and give my permission/authorization as stated regardless of whether boxes have/have not been checked.

Date: _____

Date: _____

Patient/Guardian Signature

Witness Signature

Print Name

Print Name

GEORGE C. PECK, JR., MD/ESSEX SURGICAL, LLC
776 Northfield Avenue
West Orange, New Jersey 07052
Phone: 973-324-2300
Fax: 973-324-2300

PATIENT NAME: _____

I irrevocably assign to **George C. Peck, Jr., M.D./Essex Surgical, LLC**, all my rights and benefits under my insurance contract for payment of services rendered to me by **George C. Peck, Jr., M.D./Essex Surgical, LLC**. I irrevocably authorize **George C. Peck, Jr., M.D./Essex Surgical, LLC** to file insurance claims on my behalf for services rendered to me.

George C. Peck, Jr., M.D./Essex Surgical, LLC, has made me aware that all claims will be submitted to my insurance carrier if provided. Any Co-Pay, Co-Insurance and deductible will be my responsibility. All payments are to be directed to **George C. Peck, Jr., M.D./Essex Surgical, LLC**. There will be three attempts by **George C. Peck, Jr., M.D./Essex Surgical, LLC**, to collect any debt. If **George C. Peck, Jr., M.D./Essex Surgical, LLC**, is unsuccessful in collecting your debt, it will be handed over for collections and/or suit. I understand that it is my responsibility to inform **George C. Peck, Jr., M.D./Essex Surgical, LLC**, of any insurance change to my current policy or change in insurance company, and if I do not do so, I will be fully responsible for all bills incurred related to my medical consultations, procedures and/or treatments.

This assignment of Benefits has been explained to my full satisfaction, and I understand its nature and effect. I hereby authorize photocopies of this form to be valid as the original.

Patient's Signature: _____ Date: _____

Witness: _____

THE PECK CENTER, INC.
ASSIGNMENT OF BENEFITS AND INSURANCE AUTHORIZATION

Patient Name _____ **Claim #** _____

I hereby authorize **DR. PECK/PECK CENTER, INC.,** to furnish information to insurance carriers concerning my illness and treatments. I hereby assign all payments, for medical services rendered to myself or my dependants, to the facility/ physicians. I understand that I am responsible for any amount not covered by my insurance. I UNDERSTAND THAT MY INSURANCE COMPANY HAS STATED MY COVERAGE HAS BEEN TERMINATED AND THAT I AM PERSONALLY RESPONSIBLE FOR ANY MEDICAL AND/OR FACILITY FEES CONCERNING MY ILLNESS AND TREATMENTS..

I am assigning all my rights unconditionally to **DR. PECK/PECK CENTER, INC.,** to pursue any medical bills, relating to treatment or care by this office in addition to the above.

X _____
Patient or Responsible Party's Signature

No FAULT, VICTIMS OF CRIMES AND/OR WORKERS COMPENSATION PATIENTS

I hereby authorize the release of my medical chart, bills and/or any other information related to my treatment, to my attorney:_____. I further authorize **DR. PECK/PECK CENTER, INC.,** to pursue payment of my bills.

I understand that all medical bills will be submitted to the responsible insurance carrier and will *only* be submitted to my medical insurance carrier in the event that payment is denied and/or there is a remaining balance, for which I am responsible.

I understand that I am directly and fully responsible for all medical bills submitted by you for services rendered to myself or my dependants and that this agreement is made solely for your additional protection and in consideration of your awaiting payment. I further understand that your attorney, if needed, will arbitrate my bills for payment.

X _____
Patient or Responsible Party's Signature

ATTORNEY INFORMATION

Attorney Name: _____ **Attorney Phone#:** _____

Address: _____ **City** _____ **State** _____ **Zip** _____