

MICHAEL A. GIUFFRIDA, M.D.
PATIENT REGISTRATION FORM
(PLEASE PRINT CLEARLY)

Date: _____ Name: _____ SS# _____
Address: _____ Employer: _____
City: _____ State: _____ Zip: _____ Address: _____
Phone (H) _____ Phone (W) _____ City: _____ State: _____ Zip _____
Age: _____ Birth Date: _____ Sex: _____ Occupation: _____
Mobile Phone: _____ Email Address: _____

Any Restrictions for contacting you? If so please state here: _____

Emergency Contact: _____ Telephone: _____ Relationship: _____

REFERRAL INFORMATION

Referred By: _____ Family Physician/Primary Care Physician: _____
Name: _____ Name: _____
Address: _____ Address: _____
City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____
Phone: _____ Phone: _____

HEALTH INFORMATION

Reason for visit today: _____

Height: _____ Weight: _____ Date of Last Mammogram: _____

Do you Smoke? Y N If yes, how much? _____ Are you pregnant or taking birth control pills? Y N

Medical History: Do you have or have you had any of the following? (Circle yes or no)

Rheumatic Fever	Y	N	Heart Trouble	Y	N	Heart Murmurs	Y	N	Abnormal Scarring	Y	N
Heart Palpitations	Y	N	Irregular Heart Beat	Y	N	Chest Pains	Y	N	Bleeding Problems	Y	N
Shortness of Breath	Y	N	Swelling of Ankles	Y	N	High Blood Pressure	Y	N	Emotional Problems	Y	N
Diabetes	Y	N	Cancer	Y	N	Kidney Problems	Y	N	Psychiatric Problems	Y	N
Eye Diseases	Y	N	Hepatitis	Y	N	Thyroid Problems	Y	N	Blood Transfusions	Y	N
Asthma	Y	N	Anemia	Y	N	Blood Disorders	Y	N	Sexually Transmitted Diseases	Y	N
Eye irritations	Y	N	Chronic Lung Problems	Y	N						

Any other serious illness, please explain: _____

Previous Surgery - Please list with dates: _____

Allergies: Are you allergic to or have you ever had a reaction to any medication, including local anesthetic or latex? Please list: _____

Are you now or have you ever taken any medications on a regular basis (aspirin or aspirin containing compounds, herbal supplements, vitamins included) if yes, please list below: Y N

Patient Signature: _____ Date: _____

MICHAEL A. GIUFFRIDA, MD

THIS FACILITY HAS WRITTEN POLICIES REGARDING THE RIGHTS OF PATIENTS AND IS RESPONSIBLE FOR ADHERING TO SUCH POLICIES.

PATIENT RIGHTS SHALL ENSURE THAT, AS A MINIMUM, EACH PATIENT:

1. Is informed of these rights, and of the facility's rules and regulations, including the patient's responsibility to respect the personal rights and private property of others.
2. Is informed of services available in the facility, of the names and professional status of personnel providing and/or responsible for his/her care, and of fees/charges, including any fees/charges for services not covered by insurance.
3. Is assured of medical care and is informed of his/her current medical condition unless medically contraindicated (as documented by a physician in the patient's medical record).
4. Is informed about pain and pain relief measures and to be assured that your report of pain will be believed.
5. Is informed to expect that your pain management will be provided by health care professionals who are committed to pain prevention and who respond quickly to reports of pain.
6. Has the right to participate in planning of his/her care and treatment; has the right to refuse medication and treatment; is informed of available treatment options, including the option of no treatment, and of the possible benefits and risks of each option.
7. Has the right to refuse to participate in experimental research (unless giving his/her written informed consent).
8. Has the right to express grievances to the facility's staff and governing authority and to recommend changes.
9. Is free from mental and physical abuse, free from exploitation, free from chemical, physical and other types of restraints.
10. Is assured confidential treatment of his/her medical record, and shall approve or refuse its release to any individual outside the facility, except as required by law or insurance contract.
11. Is treated with consideration, respect and full recognition of his/her dignity, individuality and right to privacy, including, but not limited to, auditory and visual privacy and confidentiality concerning patient treatment and disclosures.
12. Is not required to perform services for the facility.
13. May join with other patients or individuals to work for improvements in patient care.
14. Is assured of exercising civil and religious liberties, including the right to independent personal choices.
15. Is not the object of discrimination because of age, race, religion, sex, nationality, or ability to pay.
16. Is not deprived of any constitutional, civil, and/or legal rights solely because of receiving services from this facility.

Questions and Complaints may be presented to Michael A. Giuffrida, M.D. at 312 Hyde Park, Doylestown, PA. 18901 215-340-4900/908.284.1400.

Patient Signature

Date

MICHAEL A. GIUFFRIDA, MD

FINANCIAL POLICIES

1. There is a \$100.00 consultation fee payable at the time of your visit. Should you need to cancel your appointment, please give us 48 hours notice.
2. This consultation fee will be deducted from any surgical procedure scheduled within 3 months of the consultation date.
3. *A deposit of 20% of the cost of your procedure(s) is required to secure your surgical appointment. This deposit is **NON-REFUNDABLE**. If you cancel your procedure a minimum of 2 weeks prior to surgery, we will apply the deposit to a future surgical procedure to take place within 1 year of the deposit being made.*
4. The balance of your surgical fees must be paid a minimum of 2 weeks prior to your scheduled procedure(s) or your surgery will be rescheduled. If your procedure needs to be rescheduled due to your payment not being received within the specified time, there will be an additional charge of \$500.00 payable prior to rescheduling along with the balance of the fees for your procedure(s).
5. Your surgical fee includes the following:
 1. All procedure(s) itemized on your invoice
 2. Any additional items such as surgical garment, vitamins, massage appointments etc.
 3. OR and anesthesia fees are included if they are listed separately on your invoice.
 4. Your pre-operative visit
 5. Any and all post-operative visits within 90 days of your surgery.
6. If any additional procedures are required, you are responsible for the expenses, including surgeons fees, operating room and anesthesia costs. It is unlikely that your health insurance coverage will cover these expenses.
7. By signing below, I acknowledge having read these financial policies and I understand them. Any questions or concerns that I expressed have been addressed to my satisfaction.
8. In the rare instance that you do not tolerate intravenous sedation at 312 Hyde Park AAAASF facility for your procedure, and it is decided by the anesthesia provider and Dr. Giuffrida that general anesthesia with intubation would be more appropriate for you, you will be responsible for additional operating room and anesthesia fees for that particular surgical facility.
9. If you are late arriving for your procedure, you may have to reschedule. There may be additional fees payable prior to your procedure being performed. There will be no exceptions to this policy.

Patient Signature and Date

Rev. 6.08