ELLEN MAHONY, M.D., INC.

PHONE: (203)-221-0102 FAX: (203)-221-1121 (11/2020)

Patient Information as of ____/____/____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
First Middle Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? ❒ No ❒ Yes E-mail _____

Preferred Contact # _____

Age _____ Birthdate ___/___/___ SS# ___-___-___ Gender ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: _____ ❒ Other: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

How did you hear about *Ellen Mahony, MD, Inc.*? (Please be specific)

❒ Website _____ ❒ Event _____ ❒ Radio _____ ❒ Magazine _____

❒ Friend/Family _____ ❒ Doctor_____ ❒ Newsletter _____ ❒ Seminar _____

❒ CareCredit ❒ Newspaper ❒ Allergan ❒ Other _____

Was a female surgeon a factor in your decision today? ❒ Yes ❒ No

Emergency Contact _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Area of Interest _____

Are you now or have you ever been treated for a condition involving:

❒ Heart/Lungs	❒ Asthma/Bronchitis	❒ Sinus Trouble	❒ Psychiatric Care
❒ High Cholesterol	❒ Nervous System	❒ Muscle or Joints	❒ Depression
❒ Diabetes	❒ Liver Disease	❒ Anemia	❒ Obesity
❒ Immune System Disorder	❒ Gastrointestinal Tract	❒ Cancer	❒ Skin
❒ Blood Clotting Disorder	❒ Excessive Bleeding/Bruising	❒ High Blood Pressure	❒ Drug Abuse
❒ Check here if none apply	❒ Other _____		

Allergic to Medications? ❒ Yes ❒ No ❒ Penicillin ❒ Other _____ Foods? ❒ Yes ❒ No Type _____

Latex? ❒ Yes ❒ No Adhesives? ❒ Yes ❒ No Please list any other allergies _____

Do you take any: Aspirin? ❒ Yes ❒ No Blood Thinning Agents? ❒ Yes ❒ No Cortisone/Steroids? ❒ Yes ❒ No

Do you smoke? ❒ Yes ❒ No How Much? _____ Drink Alcohol? ❒ Yes ❒ No How Much? _____

Height _____Weight _____ Date of Last Physical ____/____/____ Primary Care Physician _____

Primary Care Physician Phone Number _____ Do you consider yourself to be in good health? ❒ Yes ❒ No

Family Medical History _____

Have you ever been hospitalized or had any surgical operations? ❒ Yes ❒ No Cosmetic Surgery? ❒ Yes ❒ No

If so, please list Month/Year _____

Any problems with anesthesia? ❒ Yes ❒ No If yes, please explain _____

Please list any medications that you are presently taking, including Vitamins, Herbal Supplements and over the counter drugs *(please include dosage):*

_____

Please list your Pharmacy name and address:

_____

FEMALE PATIENTS ONLY

Are you pregnant? ❒ Yes ❒ No # Pregnancies _____ # Children _____ Method of Birth Control _____

Problems w/ Breasts? ❒ Yes ❒ No If yes, please list _____ Last Mammogram ____/____/_____

Menstruating? ❒ Yes ❒ No Menopausal? ❒ Yes ❒ No Last Pap smear ____/____/_____ Bra Size _____

_____

How do you plan to cover the costs of this procedure? Own Funds? ❒ Yes ❒ No Credit Card? ❒ Yes ❒ No

Care Credit? ❒ Yes ❒ No Insurance? ❒ Yes ❒ No

Would you like to find out more about our finance plans? ❒ Yes ❒ No

Have you ever been involved in a malpractice lawsuit? ❒ Yes ❒ No

_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND RENDER CARE.

I have answered the above questions concerning my health to the best of my knowledge. I hereby authorize Ellen A. Mahony, MD., permission to examine me and to render appropriate care at this time. Additional consents may be required as is appropriate for specific procedures. In addition, I hereby authorize release of any pertinent information to my insurance company for the purpose of obtaining insurance coverage for a procedure or to another medical practitioner or facility for the purpose of completing the medical record.

SIGNED _____ **DATE** _____/_____/_____

24 HOUR CANCELLATION POLICY

We will confirm your office appointment 24-48 hours prior to your scheduled time. ***We kindly ask for at least 24 hours notice if you need to cancel/change your appointment time.*** Failure to show for your Injectable/Office appointment or, if notification is not received in a timely manner, will result in a $50.00 cancellation fee charged to the credit card on file.

Cardholder Name: First: _____ Last: _____

Credit Card Type: _____Visa _____Master Card

Credit Card Number: _____ - _____ - _____ - _____

Expiration Date: _____/_____/_____

Card Identification Number (last 3 digits on the back of the credit card): _____

Billing Address: _____ _____ _____ _____ _____
(Street) (Apt#) (City) (State) (Zip code)

OFFICE APPOINTMENT CHANGES

Appointment days/times are not guaranteed and may need to be rescheduled. As a surgical practice, we work collaboratively with surgical facilities and our patients. From time to time, unexpected events occur necessitating a last-minute adjustment. When, and if, we need to change your appointment, we will make every effort to provide an alternate day/time that works for you. Thank you in advance for your understanding.

_____
Print Your Name Here

_____ _____
Patient Signature Date
(3/2021)

ACKNOWLEDGEMENT OF NON-REFUNDABLE SURGICAL/PROCEDURE FEE

I acknowledge that on choosing to book a surgical date and/or office procedure, I will be required to pay a 20% non-refundable booking fee as a deposit. Care Credit may not be used for the deposit.

Refunds related to surgical cancellations are as follow:

Any surgery cancelled within 21 -14 days of your surgery will result in forfeiture of 25% of your surgical balance.

Any surgery cancelled within 14 days of the surgical date will result in forfeiture of all surgical fees (no refund).

Any cancelation due to either with-holding medical information or providing incomplete medical information will not be rescheduled or refunded (no refund).

Rescheduling of surgery is at the discretion of Dr. Mahony and will require a new payment process and signed Payment Policy. The rescheduling fee is $500.00.

Surgical/procedural refunds are not provided once surgery/services have been received.

I acknowledge that I have read and understand the Non-Refundable/Procedure Fee Policy.

_____

Print Your Name Here

_____ _____

Signature Date

(4/2021)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement if you wish.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

_____

Print Your Name Here

_____ _____

Signature Date (3/2021)

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices

This form does not constitute legal advice and covers only federal, not state, law.