THE
ROBERT ZUBOWSKI MD
CENTER FOR PLASTIC AND RECONSTRUCTIVE SURGERY

PATIENT INFORMATION

Last name:_____ First name: _____ MI:____
Address: _____
City:_____ State:_____ Zip: _____ Birthdate: _____Age:_____ Social Security No.:_____
Home Phone:(___)_____ Cell Phone:(___)_____ Work Phone:(___)_____
Email:_____ **Sex**: Male Female **Marital Status**: Single Married Widowed Divorced Patient
Occupation:_____ Employer:_____
Address:_____ City:_____ State:_____ Zip Code:_____

SPOUSE OR PARENT INFORMATION:

Spouse or Parent Name:_____
Social Security No:_____
Address:_____
City:_____ State:_____
Zip Code:_____
Phone No.(_____)_____

PHYSICIAN HISTORY:

Family Doctor:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Phone No.(_____)_____

REFERRAL INFORMATION

Referring Doctor:_____
Phone No.(_____)_____

How were you referred to our office?
Insurance Internet
Other:_____

MEDICAL INSURANCE INFORMATION

Primary Insurance:_____ Phone No.:(_____)_____
Address:_____ City:_____ State:_____ Zip Code:_____ Policy ID No:_____ Group No.:_____

Secondary Insurance:_____ Phone No.:(_____)_____
Address:_____ City:_____ State:_____ Zip Code:_____ Policy ID No.:_____ Group No.:_____
Insured's name if not the same as patient_____ Insured's Social Security No.:_____ Patient relationship to insured: Self Spouse Child Other:_____

I authorize any holder of Medical or any information including photographs about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of this physician any information used in place of the original, I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance and other health plans to Robert Zubowski, M.D. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Signature:_____ **Date**:_____

One Sears Drive Suite 102, Paramus, New Jersey 07652
Tel: 201-261-7550 Fax: 201-261-7515 www.drzubowski.com

THE
ROBERT ZUBOWSKI MD
CENTER FOR PLASTIC AND RECONSTRUCTIVE SURGERY

Health Questionnaire:

Name: _____ Date: _____

Age: _____ Sex: _____ Height: _____ Weight: _____ Occupation: _____

Internist or Family physician name: _____ Phone: _____ Last Visit: _____

Allergies:

Are you allergic to or have you had any unusual reactions to drugs, medications, or tape? (Please list each item and the ***type of reaction you had***).

PCN: _____
Sulfa: _____
Morphine: _____
Demerol: _____

Percocet: _____
Codeine: _____
Adhesive Tape: _____
Latex: _____

Tetanus: _____
Aspirin: _____
Other: _____
_____

Medications:

Do you use any of the following medications?

Aspirin ☐ tranquilizers ☐ Premarin blood thinners ☐ birth control pills ☐ Motrin/Advil ☐
Sleeping pills ☐ vitamin E ☐ diabetes medication ☐ sedatives ☐ anti-inflammatory medication ☐
High blood pressure medication ☐ omega pills or vitamins ☐

Please list any medications that you are now taking including nonprescription or over-the-counter drugs such as aspirin or Tylenol not mentioned above.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

Have you ever taken steroids such as cortisone or prednisone? Yes: ☐ No: ☐ Last used date: _____

Pharmacy: Name: _____ Phone: _____ Address: _____

Habits:

Do you smoke? Yes: ☐ No: ☐ Packs/day: _____
Do you vape? Yes: ☐ No: ☐
Do you drink alcohol? Yes: ☐ No: ☐
Do you use recreational drugs? Yes: ☐ No: ☐ Types: _____
Are you physically active?
Very active (no restriction) ☐ somewhat active (walk up the stairs) ☐ not active (unable to walk) ☐

One Sears Drive Suite 102, Paramus, New Jersey 07652
Tel: 201-261-755- Fax: 201-261-7515 www.drzubowski.com

Health History:

Date of Last: Physical: _____ PAP Smear: _____ Breast Exam: _____ Mammogram & Result: _____

Please list previous surgeries and hospitalizations including reason for hospitalization, date, hospital, and type of anesthesia.

_____

_____

_____

Have you had COVID-19? Yes ☐ No ☐ Date: _____

If yes, were you hospitalized? Yes ☐ No ☐

Have you been vaccinated? Yes ☐ No ☐

Please indicate whether you have any of the following:

Currently have: a cold ☐ bronchitis ☐ laryngitisfever ☐ sore throat ☐

Do you have: False teeth ☐ capped teeth ☐ loose teeth ☐ chipped teeth ☐

Have you or any members of your family experienced a problem with anesthesia? Yes ☐ No ☐

Problems with eyes, ears, nose, or throat? Yes ☐ No ☐

If yes, please explain: _____

	Yes	No
Diabetes	☐	☐
Cancer	☐	☐
Stroke	☐	☐
Heart disease	☐	☐
Heart trouble	☐	☐
Anemia	☐	☐
Arthritis/gout	☐	☐
Asthma	☐	☐
Enlarged glands	☐	☐
Thrombosis (blood clot)	☐	☐
Blood pressure (high/low)	☐	☐
Thyroid (overactive/underactive)	☐	☐
Convulsions	☐	☐
Seizures	☐	☐
Hay fever	☐	☐

	Yes	No
Paralysis	☐	☐
Acute infections	☐	☐
COVID	☐	☐
HIV	☐	☐
STD	☐	☐
Hepatitis	☐	☐
Phlebitis	☐	☐
Bleeding tendency	☐	☐
Clotting disorder	☐	☐
Hereditary defects	☐	☐
Kidney disease	☐	☐
Varicose veins	☐	☐
Fainting spells	☐	☐
Shortness of breath with exercise	☐	☐
Awakening at night short of breath	☐	☐

Signature: _____ Date: _____

One Sears Drive Suite 102, Paramus, New Jersey 07652
Tel: 201-261-755- Fax: 201-261-7515 www.drzubowski.com

THE
ROBERT ZUBOWSKI MD
CENTER FOR PLASTIC AND RECONSTRUCTIVE SURGERY

GENERAL MEDICAL WAIVER

I understand that my services deemed medically necessary by my physician may be "non-covered" or considered "not medically necessary" by my insurance carrier. Many insurance carriers will not pre-authorized a physician to perform a particular procedure in advance but rather will determine medical necessity after a procedure is performed. The Robert Zubowski, M.D. Center for Plastic & Reconstructive Surgery will assist you in every way possible to obtain payment for services rendered (in good faith). In the event that the insurance company denies payment based on this "lack of medical necessity," I understand that I am ultimately responsible for payment of all services rendered.

Patient/Member Signature: _____ Date:_____

ASSIGNMENT OF BENEFITS

Authorization for Assignment of Benefits

Practice Name: The Robert Zubowski, M.D. Center for Plastic & Reconstructive Surgery
Address: One Sears Drive
Suite 102
Paramus, NJ 07652
Phone Number: (201) 261-7550
Fax Number: (201) 261-7515

Patient Name (Print): _____

Insured Person: _____

Insurance Company Name: _____

Insurance Identification Number: _____

I authorize The Robert Zubowski, M.D. Center for Plastic & Reconstructive Surgery and The Center for Cosmetic & Reconstructive Surgery to furnish my insurance company assignment of benefits and obtain pre-authorization as necessary for planned procedures. I the undersigned authorized and request my insurance company referenced above to make benefits payable and mail payment to:

The Center for Cosmetic & Reconstructive Surgery and/ or Robert Zubowski, M.D.
One Sears Drive
Suite 102
Paramus, NJ 07652

By signing below, I hereby indicate that I have read this contract and understand its terms.

Patient/Member Signature:_____ Date: _____

Witness (Office Staff): _____

THE
ROBERT ZUBOWSKI MD
CENTER FOR PLASTIC AND RECONSTRUCTIVE SURGERY

HIPPA ACKNOWLEDGEMENT

Patient Name: _____ Date: _____

You may be contacted by the organization to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.

May we contact you at home? Yes/No Tel. (____)_____ OK to leave a Voice Mail? Yes/No

May we contact you at work? Yes/No Tel. (____)_____ OK to leave a Voice Mail? Yes/No

May we contact you via cell phone? Yes/No. (____)_____ OK to leave a Voice Mail? Yes/No

Comment: _____

Can a message be left with our company name and what the call is in reference to? Yes/No

Is there anyone we can leave a message with? Yes/No (If yes, please list the first and last names)

_____ _____

Would you like to authorize an individual as your personal representative? This person would have the authority to schedule, confirm or change appointments? Yes/No (If yes, please list the first and last names)

_____ _____

Do you have an Advanced Directive or Advanced Care Plan? (i.e. living will). Yes/No

Would you like information regarding Advanced Directives? Yes/No

Can you provide an Advanced Care Plan or Surrogate Decision Maker? Yes/No

(If yes, please list the contact information) _____

The Robert Zubowski, MD Center for Plastic and Reconstructive Surgery has provided me with a copy of my rights as a patient under the HIPPA act. I have been provided the opportunity to read and understand my rights and ask questions regarding my rights and received answers to my satisfaction. I authorize that all the above information is correct.

Patient Signature: _____ Date: _____

Witness (Office Staff): _____

One Sears Drive Suite 102, Paramus, New Jersey 07652 Tel: 201-261-7550 Fax: 201-261-7515
www.drzubowski.com

Covid-19 Screening

Patient: _____ **Date:** _____

Have you had COVID-19? **YES / NO** If yes, please get medical clearance prior to coming to office.

Have you been exposed to potentially COVID positive persons? **YES / NO**

Do you have any of these symptoms:

- Fever **YES / NO**
- Cough **YES / NO**
- Shortness of Breath, Difficulty Breathing **YES / NO**
- Chills **YES / NO**
- Repeated Shaking with Chills **YES / NO**
- Muscle Pain **YES / NO**
- Headache **YES / NO**
- Sore throat **YES / NO**
- New loss of taste or smell **YES / NO**

Patient Signature x _____

THE ROBERT ZUBOWSKI MD
CENTER FOR PLASTIC AND RECONSTRUCTIVE SURGERY

PATIENT'S STATEMENT OF RIGHTS AND RESPONSIBILITIES

The staff of The Robert Zubowski, MD Center for Plastic and Reconstructive Surgery, PA recognizes you have rights while a patient receiving medical care. In return, there are responsibilities for certain behavior on your part as the patient.

A patient, patient representative or surrogate has the right to:

- Receive information about rights, patient conduct and responsibilities in a language and manner the patient, patient representative or surrogate can understand.
- Be treated with respect, consideration and dignity and provided with an appropriate personal privacy.
- Expect and receive the benefits of comprehensive pain management and comfort measures.
- Have disclosures and records treated confidentially and be given the opportunity to improve or refuse record release except when release is required by law.
- Be given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.
- Receive care in a safe setting.
- Be free from all forms of abuse, neglect or harassment.
- Exercise his or her right without being subject to discrimination or reprisal with impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical disability or source of payment.
- Voice complaints and grievances, without reprisal.
- Be provided, to the degree known, complete information concerning diagnosis, evaluation, treatment and know who is providing services and who is responsible for the care. When the patient's medical condition makes it inadvisable or impossible, the information is provided to a person designated by the patient or to a legally authorized person.
- Exercise of rights and respect for properly and persons, including the right to
  *Voice grievances regarding treatment or care that is (or fails to be) furnished.
  *Be fully informed about a treatment or procedure and the expected outcome before it is performed.
  *Have a person appointed under the State law to act on patient's behalf if the patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction. Is a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.

- Refuse treatment to extent permitted by law and be informed of medical consequences of this action.

-Know if medical treatment is for purposes of experimental research and to give his consent or refusal to participate in such experimental research.

-Have the right to change primary or specialty physicians or dentists if other qualified physicians or dentists are available.

-A prompt and reasonable response to questions and requests.

-Know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

-Receive, upon request, prior to treatment, a reasonable estimate of charges for medical care and know, upon request and prior to treatment, whether the facility accepts the Medicare assignment rate.

-Receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have charges explained.

-Formulate advance directives and to appoint a surrogate to make health care decisions on his/her behalf to the extent permitted by law and provide a cope to the facility for placement in his/her medical record.

-Know the facility policy on advance directives.

-Be informed of the names of physicians who have ownership in the facility.

-Have properly credentialed and qualified healthcare professionals providing patient care.

A patient, patient representative or surrogate is *responsible* for:

-Providing a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours, unless specifically exempted from this responsibility by his/her provider.

- Providing to the best of his or her knowledge, accurate and complete information about his/her health, present complaints, past illnesses, hospitalizations, any medications, including over the counter products and dietary supplements, and allergies or sensitivities, and other matters relating to his or health.

-Accept personal financial responsibility for any charges not covered by his/her insurance.

-Following the treatment plan recommended by his health care provider.

-Be respectful of all health providers and staff, as well as other patients.

-Providing a copy of information that you desire us to know about durable power of attorney, health care provider.

-Reporting unexpected changed in his or her condition to the health care provider.

-Reporting to his health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

-Keeping appointments.

COMPLAINTS

Please contact us if you have a question or concern about your rights or responsibilities. You can ask any of our staff to help you contact the Administrative Director at the surgery center. Or, you can call 201-261-7550.

We want to provide you with excellent service, including answering your questions and responding to your concerns.

You may also choose to contact the licensing agency of the state,
Division of Health Facilities Evaluation and Licensing
New Jersey Department of Health
PO Box 367
Trenton, New Jersey 08625-0367
609-732-9770
Hotline 1-800-792-9770

If you are covered by Medicare, you may choose to contact Medicare Ombudsman at 1-800-MEDICARE (1-800-633-4227) or on line at http://www.medicare.gov/claims-and-appeals/index.html. The role of the Medicare Beneficiary Ombudsman is to ensure that Medicare beneficiaries receive the information and help your need to understand your Medicare options and to apply your Medicare rights and protections.