WELCOME TO THE PRACTICE

Please fill out these forms completely.

❑ **Mr.** ❑ **Mrs.** ❑ **Ms.** ❑ **Dr.** ❑ _____

NAME:_____
First Middle Last

MAILING ADDRESS:_____
Street Apt #

_____
City State Zip

AGE:_____ **DATE OF BIRTH:**_____ **SOC. SEC. #**:_____
month/day/year (optional)

HOME PHONE (_____)_____**WORK PHONE** (_____)_____

MOBILE PHONE (_____)_____**SECURE FAX** (_____) _____

EMAIL _____ *please read attached consent form*
(if under 18, provide parent email address)

EMERGENCY CONTACT:_____**RELATIONSHIP:**_____

EMERGENCY CONTACT PHONE (_____)_____or (_____)_____

IF UNDER 18 YEARS OLD: PARENT/GUARDIAN NAME(S)_____

EMPLOYER:_____

WORK ADDRESS:_____
Street City State Zip

Consent for Disclosure to Family Members or Personal Representative:

I have agreed to let certain individuals participate in discussion and decisions related to my medical care. Therefore, I hereby give my permission to David Rosenberg, M.D., PLLC, David Rosenberg, M.D, Jessica Lattman, M.D., PLLC, Jessica Lattman M.D, Benjamin Paul, M.D., Medical Hair Restoration, PLLC, & Manhattan Facial Surgery Suites, PLLC, employees, agents, and staff to disclose my personal medical and financial information to the following individual(s). This includes discussion of surgical procedures, account information, making of appointments, prescription concerns, pre-op and post-op care, etc.

Name:_____ Relationship:_____ Phone:(_____) _____

Name:_____ Relationship:_____ Phone:(_____) _____

Cosmetic surgery is not covered by insurance. For reconstructive surgery, it is your responsibility to submit claims to your insurance company. We are happy to provide an itemized bill after surgery.

I request payment of authorized insurance carrier benefits be made on my behalf to David Rosenberg, M.D., PLLC, Jessica Lattman, M.D., PLLC, Medical Hair Restoration, PLLC, or Manhattan Facial Surgical Suites, PLLC for any services furnished to me by that physician or entity. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. Furthermore, it is my understanding that, regardless of insurance coverage, payment for services rendered is my responsibility.

SIGNATURE:_____ **DATE:**_____

NAME:_____ **DATE:**_____

Reason for today's visit:_____

Height:_____ **Weight:**_____ **Date of Birth**:_____ **Age:**_____

Have you ever suffered from?

	Yes	No
Heart Disease	_____	_____
High Blood Pressure	_____	_____
Heart Attack	_____	_____
Emphysema	_____	_____
Asthma	_____	_____
Blood Disease	_____	_____
Kidney Disease	_____	_____
Glaucoma	_____	_____
Dry Eyes	_____	_____
Facial Trauma	_____	_____
Diabetes	_____	_____
Jaundice/Hepatitis	_____	_____
Cancer	_____	_____
Anemia	_____	_____
Easy Bruising	_____	_____
Depression	_____	_____
Eating Disorder	_____	_____
Sleep Apnea	_____	_____
Cold Sore(s)	_____	_____
Lung Disease	_____	_____
Clotting Disorder	_____	_____

List past and current medical and eye problems not mentioned above:

_____

_____

Do you take?	**Yes**	**No**
St. John's Wort	_____	_____
Aspirin	_____	_____
Ginko	_____	_____
Vitamin E	_____	_____
Coumadin	_____	_____
Lovenox	_____	_____

What medications do you use?

_____

_____

_____

_____

What medications/food are you <u>ALLERGIC</u> to?

_____

_____

When was your last Mammogram?

_____

Family medical history, please include eye conditions?

_____

_____

Have you been hospitalized? Yes____ No____

Please Describe:

_____

_____

Ever had cosmetic surgery? Yes____No____

Please Describe:

_____

_____

Ever had any other surgery? Yes____No___

Please Describe:

_____

_____

Do you currently have any of the following habits?

	Yes	No
Smoking	_____	_____
Frequency	_____	
Alcohol	_____	_____
Frequency	_____	
Recreational Drugs	_____	_____
Frequency	_____	

Have any caps, crowns, bridges or loose teeth?

_____

Are you currently undergoing dental work?

_____

Have you ever taken?	**Yes**	**No**
Fen Fen	_____	_____
Accutaine	_____	_____

When?_____

How did you hear of our office?

_____

_____

Internist Name/#: _____

_____

Cardiologist Name/#:_____

_____

Dermatologist Name/#:_____

_____

Ophalmologist/Optometrist Name/#:_____

_____

PHARMACY NAME/#: _____

_____

NAME:_____ **DATE:**_____

HAIR LOSS QUESTIONAIRE

Please Circle Answers

1. When did your hair loss begin?_____
2. I know what started my hair loss: YES / NO
   a. If yes, please describe: _____
      _____
3. Location of hair loss: SCALP / EYEBROWS / EYELASHES / BEARD / ARMS / LEGS / OTHER: _____
   a. If scalp: ALL OVER FRONT / HAIRLINE / CROWN / BACK / OTHER:_____
4. Since that time, how has your hair loss been: BETTER / WORSE / SAME
5. How rapid was the hair loss: SUDDEN / GRADUAL
6. My hair is: THINNING / BREAKING / SHEDDING
7. Within 6 months PRIOR to the onset of hair loss:
   a. Have you been started on any **new** medications? YES / NO
      If Yes, please list: _____ _____
   b. Have you had any hormone pills or birth control pills started or stopped? YES / NO
      If Yes, when: _____
   c. Have you been experiencing any significant medical issues in your life, such as the birth of a child, surgery, illness, or hospitalization?_____
   d. Have you been experiencing any significant stress, such as divorce, family illness or cancer, or work issues? _____
   e. Have you had any recent weight loss? _____
8. Any history of anemia or low iron? YES / NO Are you on any treatment? _____
9. Any history of thyroid disorders? YES / NO Are you on any treatment?_____
10. Are you actively dieting? YES / NO What type of diet? _____
11. Are you a vegetarian or vegan? YES / NO
12. Any recent lab work done to diagnose the hair loss? YES/ NO If yes, please have copies sent.
13. Does your scalp: ITCH / BURN / HURT / RASH / FLAKING / MY SCALP IS HEALTHY
14. List any family members with hair loss or thinning hair (ex: grandparents, parents, or siblings)?
    _____
15. List all prescription medications, supplements, & shampoos/solutions that you have tried for hair loss:

Treatment	When was it tried	For how long	Did it help

16. How often is your hair colored, chemically processed, or straightened? NEVER / EVERY ____ weeks
17. <u>For Women:</u>
    a. Are your periods: REGULAR / IRREGULAR
    b. Excessive hair on your chin, face, abdomen, or around nipples? YES / NO (circle any that apply)
    c. Have you had difficulty becoming pregnant: YES / NO
    d. Are you postmenopausal: YES / NO At what age? _____
    e. Have you had a hysterectomy: YES / NO When? _____
    f. Have your ovaries been removed: YES / NO When? _____
18. What type of treatment are you interested in?
    MEDICAL TREATMENT / HAIR TRANSPLANTATION/ PRP-PLATELET RICH PLASMA
    LASER HAIR GROWTH / DON'T KNOW, BUT INTERESTED IN LEARNING MORE

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby give my consent for The Office of Dr. David Rosenberg, The Office of Dr. Jessica Lattman and The Office of Dr. Benjamin Paul to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment, and Healthcare Operations (TPO). (The offices of Dr. David Rosenberg, Dr. Jessica Lattman and Dr. Benjamin Paul Notice of Privacy Practices provide a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Office of Dr. David Rosenberg, The Office of Dr. Jessica Lattman and The Office of Dr. Benjamin Paul reserve the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to The Office of Dr. David Rosenberg, The Office of Dr. Jessica Lattman or The Office of Dr. Benjamin Paul at 115 E. 61st Street, New York, NY 10065 & 225 E. 64th Street, New York NY 10065.

With this consent, The Office of Dr. David Rosenberg, The Office of Dr. Jessica Lattman and The Office of Dr. Benjamin Paul may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care.

With this consent, The Office of Dr. David Rosenberg, The Office of Dr. Jessica Lattman and The Office of Dr. Benjamin Paul may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, The Office of Dr. David Rosenberg, The Office of Dr. Jessica Lattman and The Office of Dr. Benjamin Paul may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that The Office of Dr. David Rosenberg, The Office of Dr. Jessica Lattman and The Office of Dr. Benjamin Paul restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to The Office of Dr. David Rosenberg, The Office of Dr. Jessica Lattman and The Office of Dr. Benjamin Paul use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it; The Office of Dr. David Rosenberg, The Office of Dr. Jessica Lattman and The Office of Dr. Benjamin Paul may decline to provide treatment to me.

_____ **DATE OF BIRTH:**_____

PATIENT (PLEASE PRINT)

_____ **TODAY'S DATE:** _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

EMAIL CONSENT

"Our Office" shall be understood to mean David Rosenberg, M.D., David Rosenberg, M.D., PLLC, Jessica Lattman, M.D., Jessica Lattman M.D., PLLC, Benjamin Paul, M.D., Medical Hair Restoration, PLLC, Manhattan Facial Surgery Suites, PLLC, and it's physicians, employees, staff, and agents.

Email Disclaimer

"Our Office" will use reasonable means to protect the privacy of your health information sent by email. However, because of the risks outlined below, "Our Office" cannot guarantee that email communications will be confidential. Additionally, "Our Office" will not be liable in the event that you or anyone else inappropriately uses your email. "Our Office" will not be liable for improper disclosure of your health information that is not caused by "Our Office's" intentional misconduct.

Email Risks and Your Responsibility

At the discretion of "Our Office" and upon your agreement to the terms outlined within this consent form, you may use email to communicate with "Our Office." These emails may contain your personal health information. If you decide to use email to communicate with "Our Office," you should be aware of the following risks and/or your responsibilities.

- As the Internet is not secure or private, unauthorized people may be able to read, intercept, and/or possibly modify email you send or those that are sent by "Our Office."
- You must protect your email account, password, and computer against access by unauthorized people.
- Since email can be used to spread viruses, some which cause email messages to be sent to people who you do not intend to send email messages to, you should install and maintain virus protection software on your computer.
- As your employer may claim ownership of, or the right to access, the email account issued to you by your email, you should avoid using an employer issued email account to communicate with "Our Office."

Conditions for the Use of Email

By consenting to the use of email with "Our Office," you agree that:

- Although "Our Office" will try to read and respond promptly to your emails, "Our Office" may not read your email immediately.

Therefore, you should not use email to communicate with "Our Office" if there is an emergency or where you require an answer in a short period of time.

- If your email requires or asks for a response, and you have not received a response within a reasonable time period, it is your responsibility to follow up directly with the intended recipient or office.
- "Our Office" may forward your emails as appropriate for diagnosis, treatment, reimbursement, and other related reasons. As such, other employees or agents of "Our Office," other than the recipient, may have access to emails that you send. Such access will only be to such persons who have a right to access your email to provide services to you. Otherwise, "Our Office" will not otherwise forward emails without your prior written consent, except as authorized or required by law.
- "Our Office" reserves the right to save your email and include your email or information contained within your email in your medical record.
- It is the patient's responsibility to follow up and/or schedule an appointment if warranted or recommended by "Our Office."
- You should carefully consider the risk of using email for the communication of sensitive medical information, such as, but not limited to, information regarding surgeries/procedures you are completing to undergo, or have undergone, personal health questions and information.
- You should carefully word your email messages so the information provided clearly, yet briefly, describes the information you intend to convey. You should avoid writing long emails.
- You are responsible for correcting any unclear or incorrect information.
- Emails may not be the only form of communication that "Our Office" will use to communicate with you. "Our Office" may decide that it is not in your best interest to continue to communicate with you by email. In such case, "Our Office" will notify that it no longer intends to communicate with you by email.

Email Instructions:

- You shall immediately inform those individuals with whom you communicate with at "Our Office" of changes in your email address.
- You shall send emails only to such "Our Office" email addresses as instructed.
- You shall put your name and such other information as is necessary for "Our Office" to identify you in the body of the email.
- Should you wish to discontinue communication via email you will need to do so in writing.

You consent to communicate by email by sending an email to all of the email addresses that you had previously communicated to.

I,_____, agree to the above conditions and instructions and
(Print Name)
consent to send and receive emails from "Our Office" and it's physicians, employees, staff, and agents. I understand by giving consent that I also understand in order to revoke this I must do this in writing.

SIGNATURE:_____ **DATE:**_____