

Dr. Samieh Sam Rizk, M.D., F.A.C.S
Manhattan Facial Plastic Surgery, P.L.L.C.
Director
1040 Park Avenue
New York, N.Y. 10028

Name: _____ Date of Birth: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Age: _____ Sex: M: ___ F: ___ Student? FT: ___ PT: ___
Cell Phone #: _____ Email Address: _____
Marital Status: Married: ___ Single: ___ Widowed: ___ Divorced: ___
Employer's Name: _____ Work Phone #: _____
Employer's Address: _____ City: _____ State: ___ Zip: _____
Social Security #: ___ - ___ - ___ Allergies To Medicine: _____
Primary Care Doctor (first and last name): _____ Address: _____
Referring physician: _____ Referral Phone #: _____
Name of Dermatologist: _____ Phone#: _____

Parent / Guardian / Spouse Information

Name: _____ Date of Birth: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Home Phone #: _____ Work #: _____ SS #: ___ - ___ - ___

Primary Insurance

Name of Insurance: _____ ID #: _____
Insured's Name: _____ Group #: _____
Insured's Date of Birth: _____ Insured's SS#: ___ - ___ - ___
Employer's Name: _____

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, _____, understand that I am using my out-of-network benefits for services provided to me by Dr. Samieh Rizk and/or Park Avenue Facial Surgery, and for that reason I am primarily responsible for payment of services received. I authorize payments of medical benefits to Samieh Rizk, M.D., Manhattan Facial Plastic Surgery and Park Avenue Facial Surgery (each hereinafter a "Provider" and collectively, "Provider") for any services furnished to me by the Provider(s). In exchange for not having to pay in advance for those services (or portion of services) that I am receiving which are, or may be covered by my out-of-network benefits, I agree to forward Provider(s) all checks and explanation of benefits that I receive from any of my insurance companies related to services that I have received from Provider(s) within five(5) days of receiving them, and further agree that if I fail to forward any such payment, I will be responsible for payment of the amount I receive from my insurance companies for such services, plus interest of 15% per year calculated on a daily basis at a rate of .416%, payable beginning five (5) **days** from the date that I received such payment from my insurance companies, plus all attorney's fees and cost incurred by the Provider(s) for collection of such amount(s) from me.

Patient, Parent, Or Guardian Signature (if child is under 18 years old)

Date

Health Questionnaire

Name: _____

Date: _____

Reason for today's visit: _____

1. Have you suffered from?

Yes No

Heart Disease _____

High Blood Pressure _____

Heart Attack _____

Emphysema _____

Asthma _____

Blood Disease _____

Kidney Disease _____

Glaucoma _____

Diabetes _____

Jaundice/Hepatitis _____

Cancer _____

Anemia _____

Easy Bruising _____

Facial Trauma _____

Dry Eyes _____

Eating Disorder _____

Elaborate as needed: _____

2. Do you take?

St. John's Wort _____

Aspirin _____

Ginko _____

Vitamin E _____

3. Have you have ever taken?

Fen Fen _____

Accutaine _____

4. What medications do you use?

5. What medication are you allergic to?

6. Do you have any other medical problems?

7. Have you ever been hospitalized?

yes ___ no ___ please describe:

8. Have you ever had cosmetic surgery?

Yes ___ no ___ please describe:

9. Have you ever had any other surgery?

Yes ___ no ___ please describe:

10. Have you ever had any of the following habits? Yes ___ no ___

smoking

Frequency _____

Alcohol

Frequency _____

Recreational Drugs

Frequency _____

11. Do you have any caps, crowns, bridges, or loose teeth?

12. Are you currently undergoing dental work? _____

13. How did you hear of our office?

___ Google ___ Ask.com

___ Yahoo ___ Facebook

___ AOL ___ Makemeheal.com

___ Msn/Bing ___ Other Website

___ Friend/Family ___ Physician

NASAL HISTORY SHEET
For Rhinoplasty and Nasal Patients Only

SAMIEH S. RIZK, M.D.

Patient Name: _____

Date: _____

Please read and circle the condition that best describes you:

- | | | |
|---|-----|----|
| 1. I have difficulty breathing through my nose. | Yes | No |
| 2. I have a decreased flow of air through my nose. | Yes | No |
| 3. I currently have nasal airway obstruction. | Yes | No |
| 4. I breathe through my mouth. | Yes | No |
| 5. I snore when I sleep. | Yes | No |
| 6. I have recurrent headaches. | Yes | No |
| 7. I have frequent nose bleeds. | Yes | No |
| 8. I have frequent sinus infections. | Yes | No |
| 9. I have had previous surgery on my nose | Yes | No |
| 10. Please describe nasal surgery and give approximate date. | | |
| 11. I have had an injury to my nose. | Yes | No |
| 12. Please describe injury and give approximate date. | | |
| 13. Please detail any additional information regarding your current nasal symptoms. | | |

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I authorize release of information to my insurance company.

SIGNATURE

DATE