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	◯	◯
Depression	◯	◯
Psychological Disorder	◯	◯

Elaborate as needed: _____

_____

2. Do you take?

	Yes	No
St. John's Wort	◯	◯
Aspirin	◯	◯
Ginko	◯	◯
Vitamin E	◯	◯

3. Have you have ever taken?

	Yes	No
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

For Rhinoplasty and Nasal Patients Only

SAMIEH S. RIZK, M.D.

Patient's Name: _____

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**