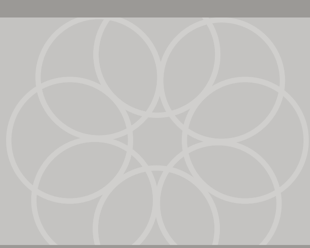


sharon giese, md

BOARD CERTIFIED PLASTIC SURGEON

Patient Registration Form

Today's Date: ___/___/______

Name: ____ Age: ______ DOB: ___ /___/______

Name by which you prefer to be addressed by office staff____

Home Address: ____
(Street) (Apt.)

____
(City) (State) (Zip Code)

Home phone: (____)_____________ Business phone: (____)_____________ Cell phone: (____)____________________

Email: ____

If visiting NY, Local Address ___________________________________ Phone: (____)___________________

Occupation: ________________________________ Employer: ____________________________________

Business Address: ____

Contact in case of emergency ____
(Name) (Phone)

Pharmacy: ______________________ Address: ______________________ Phone: (___)________________

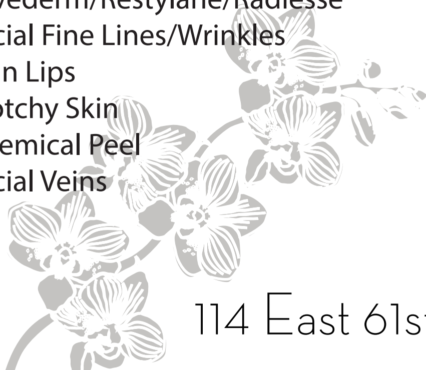
How did you hear about Dr. Giese? ____

Other than the services we have already provided for you, what additional services would you like to learn about? Please check all that apply.

Cellulite
Skin Care Products
Injectable Treatments
Juvederm/Restylane/Radiesse
Facial Fine Lines/Wrinkles
Thin Lips
Blotchy Skin
Chemical Peel
Facial Veins

Facial Redness
Brown Spots/Age spots/Freckles
Drooping Brow
Drooping Eyelids
Facial Fullness/Drooping
Scar Revision
Neck Wrinkles
Breast Size
Abdominal Area

Hips
Legs
Facial Contouring
Body Contouring
Unwanted Hair
Length/Fullness Of Eyelashes
Acne
Jowls
Dark Under Eye Circles



Medical History

Height:____ feet ____ inches Weight:____ pounds
Marital Status: ______ Number of Children:____ Ages of Children: ______________________________
The reason for my visit is: ______________________________
Prior Plastic Surgery History: Please check here if none: Otherwise, please list below:
1)____________________ date: ________ 2)____________________ date: ____________
3)____________________ date: ________ 4)____________________ date: ____________
Other: ______________________________
Current Medication(s): Please check here if none: Otherwise, please list below:
1)________________ 2)________________ 3)________________
4)________________ 5)________________ 6)________________
Herbal Medications: ______________________________
Previous Medical Operation(s): Please check here if none: Otherwise, please list below:
1)____________________ date: ________ 2)____________________ date: ____________
3)____________________ date: ________ 4)____________________ date: ____________
Any history of trouble with anesthesia ______________________________

Medical Problems (Please Check Where Appropriate): Please check here if none:
Diabetes High Blood Pressure Heart Kidney Digestive Muscle/Bone Skin Nervous System
Describe/Others: ______________________________
Drug Allergies: None 1) ____________ 2)____________ 3)____________
Do you bleed easily? Yes No
Are you taking an anticoagulant? Yes No
Do you smoke? Yes No
If yes, how much? ________ For how many years? ________ How long since your last cigarette? _______
Alcohol Consumption: Never Rarely Occasionally Often
History of Eating Disorders: ______________________________
Do you see a psychiatrist? Yes No If yes, how many times per week: _______
Are you taking any antidepressants? Yes No
Any history of drug use, including marijuana______________________________
Current Physicians Address/Location:
1)____________________ ____________________
2)____________________ ____________________
3)____________________ ____________________
Above information truthful and complete:______________________________
Signature

114 East 61st Street New York, N.Y. 10065

sharon giese, md
BOARD CERTIFIED PLASTIC SURGEON

HIPAA – Patient Consent Form

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
Obtain payment from third-party payers.
Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

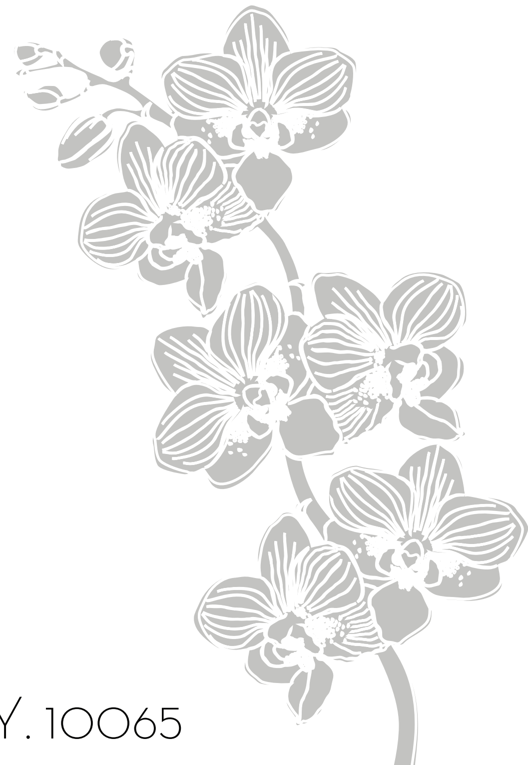
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on the consent.

Patient Name: ______________________________

Signature: ______________________ Date: __________

Relationship to patient if
other than patient: ______________________________



114 East 61st Street New York, N.Y. 10065

Covid-19 Screening Questions

1. Have you had Covid-19?

2. Have you had any of the following symptoms in the last 21 days: sore throat, cough, chills, body aches, shortness of breath, loss of smell, loss of taste, fever of greater than 100 degrees F?

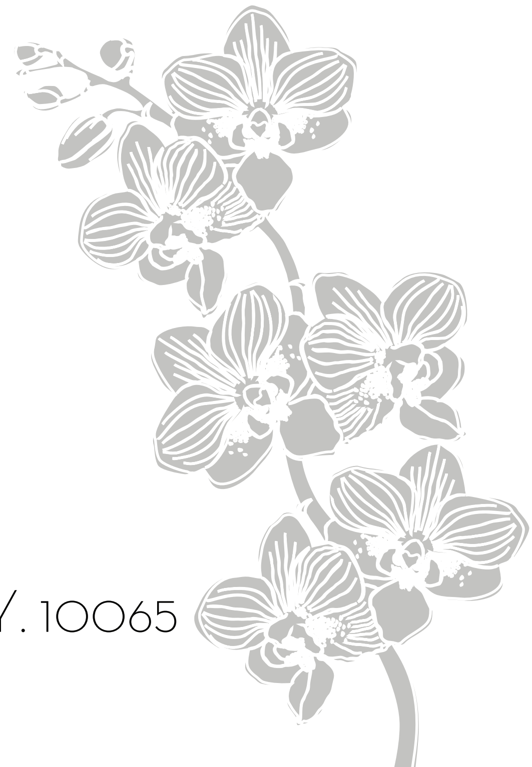
3. Visited or received treatment in a hospital, nursing home, long-term care, or other care facility in the past 30 days?

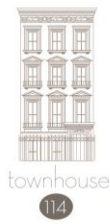
4. Traveled within the United States or on a cruise ship in the last 21 days?

5. Cared for an individual who is in quarantine, presumptive positive or test positive of Covid-19?

Are you or anyone in your household… A healthcare provider or emergency responder?

If a patient answers YES to any of any of these questions, the plastic surgeon should assess whether the patient can keep their scheduled appointment.





Sharon Giese, MD

114 East 61st Street, New York, NY 10065

APPOINTMENT CANCELLATION POLICY

Dear Patient,

Thank you for trusting your care to Sharon Giese, MD and Robin Hillary, RN. We strive to render excellent medical care to you, your family, and all of our patients. In order to be consistent with this philosophy, Dr Giese uses an appointment system that sets aside ample time for a patient dependent on the patient's current needs.

If you do not show up for your appointment, or notify us of your inability to keep your appointment by phone or email within the constraints of our policy, the time that has been allotted for your visit cannot be used to treat another patient and is time lost to our office.

Our policy is as follows:

1. We request that you please give our office 24-hours notice in the event that you need to reschedule your appointment .If your appointment is scheduled for a Monday, you must call to reschedule or cancel by the Friday before your appointment.

Our scheduling number is 212-421-3400, or you can email us at info@sharongiesemd.com.

If you miss an appointment a $150 charge will be charged. In the event of an emergency the fee may be waived.

2. If you are late for an appointment, you will be seen as soon as possible, though the office visit may need to be shortened in length.

3. As a courtesy, when time allows, we make reminder calls or emails for appointments. If you do not receive your reminder, the cancellation policy will still remain in effect

4. If you have any questions regarding this policy, please contact the office at the above address or phone number and we will be glad to clarify any questions you may have. We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy and agree to be bound by its terms.

____

Signature (Parent / Legal Guardian) Relationship to Patient

____

Printed Name Date

_____________________________ ___________ ____________

Credit Card No.* Expiration Security Code

*Please rest assured your credit card number is being held within a secured system.