JOHN K. MALLEN, M.D.
32 Stiles Road, Suite 204
Salem, NH 03079
(603) 894-9898

Date:_____

NAME:_____ Sex: Male Female

Address:_____City_____State_____Zip_____

There are occasions when it is necessary to call a patient, to discuss any pertinent information. It may also be necessary to leave a message on an answering machine or with a person. Please leave a telephone number/numbers that we can call. Also, indicate if it's a home, work or cell phone number and sign below.

***PHONE #1)*_____ HOME CELL WORK (w/ext.)**

***PHONE #2)*_____ HOME CELL WORK (w/ext.)**

E-MAIL _____

***PATIENT SIGNATURE:*_____**

Birth Date:_____ SS#:_____ Circle One: Single Married Divorced Widowed

Patient Employer Name & Address:_____

Emergency Contact & Phone:_____

Name of Primary Care Physician:_____ Referring Physician/Individual_____

Is your injury work related?_____ Auto related?_____ Date of Injury:_____

INSURANCE INFORMATION

Insurance Co._____ Group #:_____ Subscriber ID#:_____

Policyholder's Name:_____ DOB:_____ Relation to Patient:_____ SS#_____

Employer Name & Address:_____

Do you have any additional insurance? Yes No If yes, complete the following:

Policyholder's Name:_____ DOB:_____ Relation to Patient:_____

SS#:_____ Insurance Co._____ Group #_____ ID:_____

SIGNED_____ DATE_____

I authorize the taking of photographs by John K. Mallen, M.D., and/or staff for documentation and record keeping purposes.

SIGNATURE_____ DATE_____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I hereby authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediaries or carriers and insurance companies any information needed for this or related Medicare or insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits payable to John K. Mallen, M.D. I acknowledge that I am responsible for any balance not covered by my insurance company.
If we don't receive payment in full, we may take any other collection action allowed by law. You agree to pay us all reasonable costs we incur to collect this debt to the extent permitted by law. This includes court costs, attorney fees and/or collection agency fees.

SIGNATURE:_____ DATE_____

JOHN K. MALLEN, M.D.
PERSONAL MEDICAL HISTORY

	YES	NO		YES	NO
Have you ever had an eye injury?			Do you take anti-inflammatory medication?		
Do you wear glasses or contacts?			Do you have a personal history of skin cancer?		
Have you ever had a facial nerve injury?			Do you have a family history of skin cancer?		
Have you ever had impaired hearing?			Have you ever had cancer of any kind?		
Have you ever had a loss of smell?			Do you form unusually heavy scars?		
Have you ever had black out spells?			Have you ever tested positive to a skin test?		
Have you ever had seizures?			Have you ever had a skin disease?		
Have you ever had a chronic cough?			Have you ever had high blood pressure?		
Have you ever had asthma?			Have you ever had blood in stool or urine?		
Have you ever smoked?			Have you ever had a heart attack?		
Have you ever taken steroids/Cortisone?			Do you have Prolapsed Mitral Valve?		
Have you ever taken Fen/Phen or Redux?			Do you have numbness of hands and feet?		
Do you use alcohol?			Have you ever had a hand or arm injury?		
Do you take aspirin daily?			Are you diabetic?		
Do you use eye drops regularly?			Other? [*Please list*]		
Do you take arthritis medication?					
Have you ever had radiation therapy?					

If the following do not apply, please indicate by writing none or n/a:

List all allergies	List all prescription medications. Also include all herbal, natural health food store, weight loss and/or energy drugs taken.
List previous surgeries	
List all pregnancies	

REASON FOR VISITING OUR OFFICE TODAY_____

Answering the following questions is OPTIONAL. This information helps us to better serve our patients.

How did you hear about us? Referral by _____Physician ____Patient _____Friend

_____Yellow Pages Ad_____ ____ Mailing to home _____ Attended Seminar_____
(which town and phone book) *(place)*

Are you interested in attending a free seminar? YES NO

Are you interested in obtaining more information on the any of the following?

Cosmetic Surgical Procedures_____ Cosmetic Non-Surgical Procedures_____

Non-Surgical Skin Rejuvenation_____ Home skin care products _____

PATIENT'S NAME:_____ DATE:_____

JOHN K. MALLEN, M.D.
PLASTIC & RECONSTRUCTIVE SURGERY
COSMETIC SURGERY
32 STILES ROAD, SUITE 204
SALEM, NH 03079
(603) 894-9898
FAX: (603) 894-6270
www.drjohnmallen.com

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by John K. Mallen, M.D. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of John K. Mallen, M.D. I understand that diagnosis or treatment of me by John K. Mallen, M.D. may be conditioned upon my consent as evidenced by my signature of this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. John K. Mallen, M.D. is not required to agree to the restrictions that I may request. However, if John K. Mallen, M.D. agrees to a restriction that I request, the restriction is binding on John K. Mallen, M.D.

I have the right to revoke this consent in writing, at any time, except to the extent that John K. Mallen, M.D. has taken action in reliance on this consent.

My "protected health insurance" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review John K. Mallen, M.D.'s Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the John K. Mallen, M.D. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of John K. Mallen, M.D.

The Notice of Privacy Practices of John K. Mallen, M.D. is also provided, 32 Stiles Road, Suite 204, Salem, NH 03079. This Notice of Privacy Practices also describes my rights and John K. Mallen, M.D.'s duties with respect to my protected health information.

John K. Mallen, M.D. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing John K. Mallen M.D.'s web site, calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Name of Patient of Personal Representative **Relationship to Patient**