BROWN
Alpert Medical School

Richard J. Zienowicz, M.D., FACS
Plastic & Reconstructive Surgery

Patient Information

Title: **Date of Birth:**

Name:

Address:

City State Zip

SSN: Marital Status:

Telephone information:

Home: Mobile: Work:

Which number is preferred should we need to contact you:

Email Address:

Employer: Occupation:

Address:

Primary Care Physician: Telephone Number:

Address:

Allergies:

Pharmacy Name: **Telephone Number:**

Emergency Contact:

Telephone: Relationship:

Health Coverage Information:

Coverage & Policy Number:

Subscriber's Name: **DOB:** **Relationship:**

Additional Health Insurance:

Subscriber's Name DOB: Relationship:

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Workers' Compensation Information – Is visit related to work-related accident or issue?

If yes, has accident/issue been reported? :

Workers' Compensation Insurance Information:

Address: Telephone Number:

Contact: Claim Number:

Authorization to Pay Benefits to Physician: I hereby authorize payment directly to Richard J. Zienowicz, M.D. for all surgical and/or medical benefits.

Authorization to Release Information: I hereby authorize Richard J. Zienowicz, M.D. to release information acquired in the course of my examination or treatment necessary to process medical claims for myself and/or my child.

Signature: *Date:*

Referral Information: We would appreciate learning how you heard about us:

Current Patient, Friend or Family Member:

Physician Referral:

Website or other Media Publication:

Other:

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Patient Consent

Name:

Do we have your permission to: Yes / No

Call you directly:

Leave a message on any message device:

Call you at work and leave a message:

Contact you via email:

Discuss your medical/surgical appointment with another person:

If yes, name of authorized individual:

Mail an appointment reminder, test result or other information to your home mailing address:

Please specify any restrictions:

Signature of Patient / Parent *Date*

113 Wickenden Street, Providence, RI 02903
We respectfully request all information is provided as requested above

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Patient Encounter Information

Reason for appointment:

If injury related, date and location:

Medications you are taking presently, i.e. birth control, anti-depressants, tranquilizers, blood pressure, aspirin, blood thinner. List any and all:

Provide history of medical conditions, serious illness and past surgeries:

Alcoholic beverage consumption weekly:

Smoker: If yes, how many cigarettes per day? :

Please check & identify any of the following conditions you are or have been treated for:

Bleeding Tendency:	Asthma:	Diabetes:	Cancer:
Heart Disease:	Epilepsy:	Kidney Disease:	Tuberculosis:
Vascular Disease:	Arthritis	High Blood Pressure:	

Other:

Patient Signature: *Date:*

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