

# PATIENT INFORMATION

PLEASE PRINT

NAME \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

ZIP CODE \_\_\_\_\_ SEX (M/F) \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

EMPLOYED BY \_\_\_\_\_ AGE \_\_\_\_\_

POSITION HELD \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

OUT-OF-STATE-ADDRESS \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ DRIVER'S LICENSE # \_\_\_\_\_

## SPOUSE OR PARENT/GUARDIAN INFORMATION

E-MAIL ADDRESS: \_\_\_\_\_

NAME \_\_\_\_\_ RELATION TO PATIENT \_\_\_\_\_

EMPLOYED BY \_\_\_\_\_ WORK PHONE \_\_\_\_\_

## SUBSCRIBER INFORMATION

If someone other than the patient is responsible for payment, please complete this section.

NAME \_\_\_\_\_ RELATION TO PATIENT \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ EMPLOYER \_\_\_\_\_

HOME PHONE # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

## GENERAL INFORMATION

REFERRED BY \_\_\_\_\_

REASON FOR SEEING DOCTOR \_\_\_\_\_

IF ACCIDENT, DATE OF INJURY \_\_\_\_\_ IS INJURY RELATED TO AUTO ACCIDENT: \_\_\_\_\_

DO YOU HAVE AN ATTORNEY FOR THIS PROBLEM? \_\_\_\_\_

ARE YOU ALLERGIC TO ANY MEDICATION? \_\_\_\_\_ PLEASE LIST: \_\_\_\_\_

## INSURANCE INFORMATION

If you have your insurance I.D. card(s) with you, please let the receptionist make a copy for your records.

Health Insurance: \_\_\_\_\_ ID# \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber's Employer: \_\_\_\_\_ Telephone: \_\_\_\_\_

Medicare # \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

**PHOTOGRAPHS** - Pre- and post-operative photographs are essential in Plastic Surgery both for planning and for analysis of post-operative results. It is the policy of this office that ALL patients coming in for consultation will have photographs taken, even if surgery is not contemplated in the near future. These photographs are intended solely for use in this office. They cannot be shown to any prospective patients, nor can they be used in any talks or demonstrations without the expressed permission of you, the patient.

I have read the above and fully understand the implications. I hereby give my consent to allow \_\_\_\_\_ to take pre-operative, intra-operative and/or post-operative photographs of me.

Signed \_\_\_\_\_ Date \_\_\_\_\_

(Parent/Guardian, if patient is a minor)

## RELEASE OF INFORMATION/MEDICAL RECORDS and ASSIGNMENTS OF BENEFITS:

I hereby authorize **Dr. Jonathan Berman** to release any information acquired in the course of my examination or treatment to my attorneys, physicians and/or insurance companies. Thereby authorize payment directly to **Dr. Jonathan Berman** for the surgical benefits AND/OR major medical benefits if otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all charges whether or not paid by my insurance. This includes reasonable attorney's fees and costs of collection @ 35% of balance due. I hereby authorize photocopies of this form to be as valid as the original. This statement will remain in effect until revoked by me in writing.

Signed \_\_\_\_\_ Date \_\_\_\_\_

(Parent/Guardian, if patient is a minor)

Please Answer Each Question

(For Doctor's Use Only)

**MEDICAL INFORMATION**

**LIST ALL PREVIOUS SURGERY/HOSPITALIZATION, INCLUDING REASON:**

| Surgery-Hospitalization/Reason | Hospital | Type of Anesthesia | Year |
|--------------------------------|----------|--------------------|------|
|                                |          |                    |      |
|                                |          |                    |      |
|                                |          |                    |      |

**LIST ALL MEDICATIONS YOU ARE TAKING, INCLUDING EYE DROPS , OINTMENTS, HERBAL MEDICATION:**

| Medications | Dosage Amount | How Often Each Day |
|-------------|---------------|--------------------|
|             |               |                    |
|             |               |                    |
|             |               |                    |

**CHECK ANY OF THE FOLLOWING WHICH YOU HAVE, OR HAVE HAD:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Emphysema                           | <input type="checkbox"/> High or Low Blood Pressure | <input type="checkbox"/> Tuberculosis                                    |
| <input type="checkbox"/> Asthma/Bronchitis                   | <input type="checkbox"/> Heart Murmur               | <input type="checkbox"/> Cancer  |
| <input type="checkbox"/> Stomach Problems                    | <input type="checkbox"/> Irregular/Fast Heartbeat   | <input type="checkbox"/> Stroke  |
| <input type="checkbox"/> Ulcers                              | <input type="checkbox"/> Angina                     | <input type="checkbox"/> Headaches                                       |
| <input type="checkbox"/> Diabetes                            | <input type="checkbox"/> Rheumatic Fever            | <input type="checkbox"/> Seizure Disorder/Epilepsy                       |
| <input type="checkbox"/> Pancreas Disorders                  | <input type="checkbox"/> Circulatory Problems       | <input type="checkbox"/> Blood Transfusion Reactions                     |
| <input type="checkbox"/> Liver Disease/Hepatitis/Jaundice    | <input type="checkbox"/> Glaucoma                   | <input type="checkbox"/> Excessive Bleeding                              |
| <input type="checkbox"/> Kidney Disorders/Bladder Infections | <input type="checkbox"/> Cataracts                  | <input type="checkbox"/> Arthritis                                       |
| <input type="checkbox"/> Prostate Problems                   | <input type="checkbox"/> Dry Eye Syndrome           | <input type="checkbox"/> Thyroid Disorder                                |
| <input type="checkbox"/> Psychiatric Treatment               | <input type="checkbox"/> Fainting Spells/Syncope    | <input type="checkbox"/> Pre-Menstrual Syndrome                          |
| <input type="checkbox"/> MITRAL-VALVE PROLAPSE               | <input type="checkbox"/> JOINT REPLACEMENT          | <input type="checkbox"/> PACEMAKER <input type="checkbox"/> HYSTERECTOMY |

**YES NO**

- Do you have any skin problems? If yes, describe: \_\_\_\_\_
- Are you pregnant? \_\_\_\_\_
- Do you smoke? If yes, how much per day? \_\_\_\_\_
- Are you a former smoker? If yes, when did you stop smoking? \_\_\_\_\_
- Do you drink alcoholic beverages? If yes, how much per day? \_\_\_\_\_
- Do you have vision problems? If yes, explain: \_\_\_\_\_
- Do you wear eyeglasses? \_\_\_\_\_
- Do you wear contact lenses? \_\_\_\_\_
- Do you wear removable dental appliance/denture(s)? \_\_\_\_\_
- Do you have dental caps or crowns? \_\_\_\_\_
- Do you now, or have you ever used "street drugs"? \_\_\_\_\_
- Do you have any allergies to foods, medications or environment? If yes, explain: \_\_\_\_\_
- DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK THE DOCTOR SHOULD KNOW ABOUT? If yes, explain: \_\_\_\_\_

**PRIVATE/PERSONAL PHYSICIAN:** \_\_\_\_\_ Date Last Exam \_\_\_\_\_

ADDRESS \_\_\_\_\_ T

elephone # \_\_\_\_\_ Date Last EKG \_\_\_\_\_

Last Known Blood Pressure \_\_\_\_\_ Height \_\_\_\_\_ Current Weight \_\_\_\_\_ Date Last Chest X-Ray \_\_\_\_\_

**\*\*\*I HAVE READ (or have had read to me) THE ABOVE MEDICAL INFORMATION LISTING AND I HEREBY CERTIFY THAT THE INFORMATION I HAVE PROVIDED ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE.**

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Parent/Guardian, if patient is a minor)