GLASSMAN PLASTIC SURGERY, PLLC

LAWRENCE S. GLASSMAN, M.D.

PATIENT NAME:_____
FIRST NAME MIDDLE NAME LAST NAME
STREET ADDRESS:_____
CITY:_____STATE:_____ZIP CODE_____SEX: M__F__

E-MAIL:_____
HOME PHONE:_____CELL PHONE_____
DATE OF BIRTH_____SS#_____MARITAL STATUS: S___M___D___W_____
REFERRING PHYSICIAN/FRIEND_____RACE:_____
EMPLOYER:_____WORK PHONE:_____
EMPLOYER ADDRESS_____
SPOUSE'S EMPLOYER:_____SPOUSE WORK PHONE_____
SPOUSE'S EMPLOYERS ADDRESS:_____
EMERGENCY CONTACT NAME_____PHONE#_____

PRIMARY
INSURANCE:_____POLICY#_____
PRIMARY CARE PHYSICIAN_____GROUP#_____
ADDRESS:_____TELEPHONE#:_____
RELATIONSHIP TO INSURED:_____
POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT):_____
SS# OF POLICY HOLDER (IF DIFFERENT FROM PATIENT):_____
DATE OF BIRTH OF POLICY HOLDER (IF DIFFERENT FROM PATIENT):_____

SECONDARY
INSURANCE:_____POLICY#_____
ADDRESS:_____TELEPHONE#_____
RELATIONSHIP TO INSURED:_____
POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT):_____
DATE OF BIRTH OF POLICY HOLDER (IF DIFFERENT FROMPATIENT):_____

TERTIARY
INSURANCE:_____POLICY#_____
RELATIONSHIP TO INSURED:_____DOB:_____
POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT):_____
DATE OF BIRTH OF POLICY HOLDER (IF DIFFERENT FROM PATIENT):_____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO GLASSMAN PLASTIC SURGERY, PLLC, ATTORNEY FEES AND COSTS OF COLLECTION IN THE EVENT OF DEFAULT UP TO 33% ADDITIONAL CHARGE FOR COLLECTION FEE. INSURANCE IS NOT ACCEPTED AS PAYMENT IN FULL.

SIGNED:_____**DATE:**_____

I AUTHORIZE ANY HOLDER OF MEDICAL OR ANY OTHER INFORMATION ABOUT ME TO RELEASE MY INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE AND FINANCING ADMINISTRATIONS, ITS INTERMEDIARIES, CARRIERS INSURANCE COMPANIES, BILLING AND COLLECTION AGENTS OF THESE PHYSICIANS.

SIGNED:_____**DATE:**_____

Like us on Facebook @GlassmanPlasticSurgery

YOUR INSURANCE

In the past few years the number of different health insurance programs has increased at an amazing rate. Even within one company, there may be several programs with varying benefit requirements. There is no way that we can possibly know, or keep up to date, with each provision.

Some programs require that a specific facility be used for your x-ray's, ultrasound or blood tests.

Some programs require pre-authorization, while others do not.

Some insurance companies require PATIENTS to notify them of hospital admits or trips to the emergency

It is YOUR RESPONSIBILITY to know:

1. Whether this office is participating with your particular plan and program.
2. Advise this office of your program's requirements in advance, each and every time we provide a service. We will do our very best to comply with any reasonable requirements that your program may have.

Please understand that if we have not been advised in advance, of your programs requirement or conditions and we provide a service or use a laboratory that is outside of the program, you will be responsible for appropriate fees.

In addition, there are times that we may not be able to obtain a consultant or laboratory participating with your program. It will be up to you to work this out with your insurance company.

These are not our regulations, they are your insurance company's regulations and unless you follow them carefully, the insurance company may decline all or part of your claim. Your insurance company should have provided you with a phone number for you to use if you have any questions about your coverage. Please be sure to keep this page with your insurance papers for future references.

I acknowledge receipt of this information.

_____ _____

Signature Date

_____

Please print your name

NEW PATIENT INFORMATION SURVEY

Patient :Last Name:_____First Name:_____

Date of First Visit: **Month_____Day_____Year_____**

Reason For Visit: **Cosmetic/Type_____**

How did you hear about us (check all that apply)?

- ❑ **Internet: (Which Site) _____**
- ❑ **Friend/Relative**
- ❑ **Physician/Hospital**
- ❑ **Television**
- ❑ **Newspaper: (Which Paper)_____**
- ❑ **Radio**
- ❑ **Yellow Pages**

Thank You!

PATIENT HIPAA AWARENESS

With my permission, Drs. Glassman may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Drs. Glassman Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Drs. Glassman reserve the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Drs. Glassman may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Drs. Glassman may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and or Confidential.

With my permission, the office of Drs. Glassman may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to a "request that Drs. Glassman restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Drs. Glassman to use and disclosure my PHI for TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient or Legal Guardian (include relationship to patient)

SMOKING CONSENT

I UNDERSTAND THAT SMOKING BEFORE OR AFTER SURGERY WILL ADVERSELY EFFECT THE HEALING AND CIRCULATION AND WILL JEOPARDIZE MY SURGICAL OUTCOME.

PLEASE CHECK OFF WHAT BEST PERTAINS TO YOU.

_____ I NEVER SMOKED

_____ I HAVE NOT SMOKED IN OVER 5 YEARS

I STOPPED SMOKING ON _____

_____ DO YOU WEAR A NICOTINE PATCH?

_____ I STILL SMOKE

DATE: _____

PATIENT: _____

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HISTORY INTAKE FORM

PATIENT NAME:_____ BIRTHDATE:_____ AGE:_____
SOCIAL SECURITY#_____ PRIMARY CARE DOCTOR:_____
Smoking(type & amount per day)_____ Alcohol(type & amount per week)_____
If former smoker, date quit:_____ Weight:_____ Height: _____
TYPE OF WORK:_____
LIST PREVIOUS SURGERIES OR MAJOR ILLNESS AND DATES: _____
_____
DRUG ALLERGIES(include Reaction): _____
_____
LIST ANY MEDICATIONS (with Doses) you are taking, including non-prescription drugs, vitamins and herbs:
_____
_____
Do you use Aspirin, Ibuprofen (Advil), or any over the counter pain medication regularly?_____
Are you taking Vitamin Supplements? _____ Do you take steroids?_____ Do you use growth hormones?_____
DATE IF LAST TENTANUS SHOT: _____

FAMILY HISTORY:

Has any blood relative ever had the following:

Breast Cancer.....no	yes	High Blood Pressure.....no	yes	Kidney Disease.....no	yes
Melanoma.....no	yes	Heart Disease.....no	yes	Stroke.....no	yes
Diabetes.....no	yes	Deep Vein Thrombosis...no	yes	Malignant Hyperthermia.no	yes
		Pulmonary Embolus.....no	yes		

PERSONAL PAST MEDICAL HISTORY:

Have you ever had the following:

Heart Disease.....no	yes	Cancer.....no	yes	Stomach Ulcer.....no	yes
Chest pain.....no	yes	Arthritis.....no	yes	Glaucoma.....no	yes
Rapid heart beat.....no	yes	Kidney Disease.....no	yes	Dry eyes.....no	yes
Rheumatic Fever...no	yes	Asthma.....no	yes	Thyroid Disease.....no	yes
Anemia.....no	yes	AIDS or HIV+.....no	yes	Bleeding Tendency.....no	yes
Tuberculosis.....no	yes	Stroke.....no	yes	Mitral Valve Prolapse....no	yes
Diabetes.....no	yes	Hepatitis.....no	yes	High Blood Pressure.....no	yes
Skin Rash.....no	yes	Swollen feet/ankles.....no	yes	Seizures.....no	yes
Chronic Diarrhea...no	yes	Swollen lymph nodes.....no	yes	Joint or muscle pain.....no	yes
Chronic cough.....no	yes	Jaundice.....no	yes	Easy bruising.....no	yes
Depression.....no	yes	Deep Vein Thrombosis.....no	yes	Easy bleeding.....no	yes
Weight Change.....no	yes	Pulmonary Embolus.....no	yes	Sleep Apnea.....no	yes
		Malignant Hyperthermia..no	yes		

WOMEN ONLY: (IF APPLICABLE)
Do you take oral birth control pills? _____ Do you use hormone replacement therapy? _____
Age period began:_____ Number of pregnancies:_____
Date of last mammogram:_____ Number of miscarriages:_____
Do you do regular breast self-examination?_____ Breast lump or discharge:_____
Did you breast feed?_____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

_____ DATE: _____
SIGNATURE OF PATIENT OR PARENT