GLASSMAN PLASTIC SURGERY, PLLC

LAWRENCE S. GLASSMAN, M.D. & DONOVAN ROSAS, M.D.

PATIENT NAME:_____
FIRST NAME MIDDLE NAME LAST NAME
STREET ADDRESS:_____
CITY:_____STATE:_____ZIPCODE_____SEX: M_____F_____
HOME PHONE:_____CELL PHONE_____E-MAIL:_____
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:_____
IF FULL-TIME STUDENT INDICATE SCHOOL ATTENDING:_____

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 FROM PATIENT):_____
DATE OF BIRTH OF POLICY HOLDER (IF DIFFERENT FROM PATIENT):_____
TERTIARY
INSURANCE:_____POLICY#_____
RELATIONSHIP TO INSURED:_____DOB:_____
POLICY HOLDER NAME (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 TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE D FINANCING ADMINISTRATIONS OR ITS INTERMEDIARIES OR CARRIERS, OR TO THE BILLING AGENT OF THIS PHYSICIAN, ANY INFORMATION USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

SIGNED:_____**DATE:**_____

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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: _____
LIST PREVIOUS SURGERIES OR MAJOR ILLNESS AND DATES: _____
_____
DRUG ALLERGIES: _____
LIST ANY MEDICATIONS YOU ARE TAKING, INCLUDING NON-PRESCRIPTION DRUGS, VITAMINS & HERBS: _____
_____
Do you use Aspirin, Ibuprofen (Advil), or any over the counter pain medication regularly?_____
Do you take oral birth control pills? _____ Do you use hormone replacement therapy? _____
Are you taking Raloxifene? _____ 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						

PAST MEDICAL HISTORY:
Have you ever had the following:

Heart Disease	no	yes	Cancer	no	yes	Stomach Ulcer	no	yes
Arthritis	no	yes	Glaucoma	no	yes	Kidney Disease	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
Depression	no	yes						

REVIEW OF SYSTEMS:
Do you have now or have you had within the past year:

Weight Change	no	yes	Swollen feet/ankles	no	yes	Seizures	no	yes
Dry eyes	no	yes	Skin Rash	no	yes	Joint or muscle pain	no	yes
Chronic cough	no	yes	Chronic Diarrhea	no	yes	Swollen lymph nodes	no	yes
Chest pain	no	yes	Jaundice	no	yes	Easy bleeding	no	yes
Rapid heart beat	no	yes	Depression	no	yes	Easy bruising	no	yes

WOMEN ONLY: (IF APPLICABLE)
Age period began:_____ Number of pregnancies:_____
Date of last mammogram:_____
Do you do regular breast self-examination?_____ Breast lump or discharge:_____
Did you breast feed?_____
TYPE OF WORK:_____

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

_____ DATE: _____
SIGNATURE OF PATIENT OR PARENT

PATIENT HIPAA AWARENESS

With my permission, Drs. Glassman and Rosas may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Drs. Glassman and Rosas 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 and Rosas 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 and Rosas 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 & Rosas 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 & Rosas 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 request that Drs. Glassman & Rosas 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 & Rosas to use and disclose 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 Patient's Name

Date Print Name of Patient or Legal Guardian

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

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: _____

WITNESS: _____

Lawrence S. Glassman, MD, FACS *
Donovan T. Rosas, MD

Certified by the American Board of Plastic Surgery
American Society of Plastic Surgery
** American Society for Aesthetic Plastic Surgery**
** Fellow American College of Surgeons**

NAME_____ DATE_____

In the event that the Insurance Company send payment for Doctor's fees or Operating Room fees (Natural Images in Plastic Surgery) to me, I understand that it is my responsibility to endorse that check over to the Doctor.

In the event that I fail to do so, I understand that I am responsible for payment of that full amount to the Doctor.

_____

SIGNED

Glassman Plastic Surgery, PLLC
Highmount Building • 311 North Midland Avenue • Upper Nyack, NY 10960
(845) 353-2828 fax (845) 353-4121
www.glassmanplasticsurgeryNY.com

Lawrence S. Glassman, MD, FACS *
Donovan T. Rosas, MD

Certified by the American Board of Plastic Surgery
American Society of Plastic Surgery
* American Society for Aesthetic Plastic Surgery
* Fellow American College of Surgeons

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?

- ❑ **Television**
- ❑ **Journal News**
- ❑ **Internet (Which Site)** _____
- ❑ **Times Herald Record**
- ❑ **PennySaver**
- ❑ **Yellow Pages**
- ❑ **Radio**
- ❑ **Friend/Relative**
- ❑ **Physician/Hospital**

Thank You!

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