

GLASSMAN PLASTIC SURGERY, PLLC
LAWRENCE S. GLASSMAN, M.D.

PATIENT NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE _____ SEX: M ___ F ___

E-MAIL: _____

HOME PHONE: _____ CELL PHONE _____

PREFERRED WAY TO CONTACT YOU: CELL HOME EMAIL (Please circle one)

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# _____

PHARMACY NAME _____ ADDRESS _____ 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 FROM PATIENT): _____

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, Dr. Glassman may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr. 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. Dr. Glassman reserves 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 Dr. 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 Dr. 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 Dr. 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 Dr. 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 Dr. 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: _____

GLASSMAN PLASTIC SURGERY, PLLC

LAWRENCE S. GLASSMAN, M.D.

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? _____

Do you use Recreational Drugs? _____ DATE OF LAST TETANUS 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