

New York Group for Plastic Surgery, LLP

Welcome to Our Office

Patient's Name: _____ Today's Date: _____
 First Middle Last Sex M F
Home Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____ Cell Phone: _____ Birth date: _____ Age: _____
Occupation: _____ Social Security Number: _____
Employer: _____ Length of Employment: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Employer's Telephone: (_____) _____

E-Mail Address: _____

(For information use only, i.e., spa newsletter or promotions. The NYGPS does not share or sell email info with anyone).

Medical Records # (for office use only) #: _____
Mother's Name: _____ Father's Name: _____
Primary Physician: _____ Phone # _____
In the case of an emergency, contact _____ Relationship: _____
Home Phone: _____ Work Phone: _____
How did you learn about the New York Group for Plastic Surgery: _____
Referred by: _____

Insurance Information

Responsible Party: _____ Relationship to Patient: _____
[Primary]

Name and Address of Insurance Company: _____

City: _____ State: _____ Zip: _____

Insured's Name: _____ **Insured's Date of Birth/& S.S#** _____

Group #: _____ Policy ID #: _____

Effective Date of Coverage: _____ Employer: _____

[Secondary]

Name and Address of Company: _____

City: _____ State: _____ Zip: _____

Insured's Name: _____ Insured's Date of Birth: _____

Group #: _____ Policy ID #: _____

Effective Date of Coverage: _____

Employer: _____

Our office will file insurance for your procedure charges only. Office visits are payable on the day you are seen. Please remember you are responsible for all fees, regardless of insurance coverage.

Signature: _____ Date: _____

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Patient History

In order for your physician to better meet your medical and surgical needs, please take a moment to carefully answer the following questions. Circle Y for yes and N for no or write your response on the appropriate line. This will assist us in providing you with the highest quality of care. Thank you.

Name: _____ Age: _____ Height: _____ Weight: _____

Reason you are seeing the doctor today: _____

List any medical conditions that you are currently being treated for: _____

List any medications you are currently taking: _____

List any allergies that you have, including any allergies to medications: _____

List any surgical procedures you have had, please note the year performed: _____

Have you had any problems with anesthesia in the past? _____

How much do you smoke (packs per week)? _____

How much alcohol do you drink in a week? _____

Please list family history of disease: _____

Do you have a family history of breast cancer?: _____

Last Mammogram? _____ # of children (yrs.) _____

I authorize the release of any medical information necessary to process this claim and authorize payment of medical and surgical benefits to the New York Group for Plastic Surgery.

PRINT PATIENT'S NAME

PRINT GUARANTOR'S NAME

SIGNATURE OF PATIENT

SIGNATURE OF GUARANTOR

DATE: _____

