Plastic Surgery Patient Information

Date: _____

Salutation: _____ First Name: _____ Middle Initial: ___ Last Name: _____

Address: _____

_____

_____

City: _____ State: ____ Zip Code: _____

E-mail: _____ Marital Status: _____ Name of Spouse: _____

Birth Date: _____ Age: _____ Sex: ___ SS #: _____

Ethnicity: _____

Occupation: _____

Home Number: ( ) -

Work Number: ( ) - x

Cell Number: ( ) -

Other Number: ( ) - x

Fax Number: ( ) -

If Minor, SS # of Guardian: _____

Work Address

Company: _____

Address: _____

_____

_____

City: _____ State: ____ Zip Code: _____

Emergency Contact

Name: _____

Address: _____

_____

_____

City: _____ State: ____ Zip Code: _____

Phone Number: ( ) - x Relationship to you: _____

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

Advertisement ☐ Internet ☐ Friend ☐ Other ☐ _____

Physician Referral ☐

Name: _____

Address: _____

_____

_____

Phone Number: ( ) - x

Fax Number: ( ) -

City: _____ State: ____ Zip Code: _____

Primary Care Physician

Name: _____

Address: _____

_____

_____

Phone Number: ( ) - x

Fax Number: ( ) -

City: _____ State: ____ Zip Code: _____

Primary reason for visit:

_____

_____

Other procedures that I am interested in (Please check all that apply):

Liposuction: ☐	Face Lift: ☐	Breast Augmentation: ☐	Laser Resurfacing: ☐
Tummy Tuck: ☐	Neck Lift: ☐	Breast Reduction: ☐	Chemical Peels: ☐
Body Lift: ☐	Eyelid Surgery: ☐	Breast Lift: ☐	Botox Injections: ☐
Arm Lift: ☐	Brow Lift: ☐	Breast Reconstruction: ☐	Fat Grafting: ☐
Buttock Lift: ☐	Forehead Lift: ☐	Male Breast Surgery: ☐	Collagen Injections: ☐
Thigh Lift: ☐	Nose Surgery: ☐	Hand Surgery: ☐	Scar Revisions: ☐

Past Surgical History

Please list all operations you have had below
Including Plastic and Cosmetic Procedures

Date ___/___/___ Type _____
Date ___/___/___ Type _____
Date ___/___/___ Type _____
Date ___/___/___ Type _____
Date ___/___/___ Type _____
Date ___/___/___ Type _____
Date ___/___/___ Type _____
Date ___/___/___ Type _____
Date ___/___/___ Type _____
Date ___/___/___ Type _____
Date ___/___/___ Type _____

Past Medical History

	Currently	In the Past
Chick Pox		
Measles		
Mumps		
German Measles		
Kidney Disease		
Hypertension		
Arthritis		
Asthma		
Emphysema		
Respiratory Problems		
Seizures		
Cancer		
Rheumatic Fever		
Scarlet Fever		
Polio		
Tuberculosis		
Hepatitis		
Diabetes		
Heart Disease		
Heart Attack		
Angina		
Stroke		
Anemia		
DVT or PE	Yes	No
Bleeding Tendency	Yes	No
Zoster	Yes	No
Herpes	Yes	No
HIV or AIDS	Yes	No

Breast History

Date of last mammogram ___/___/___
History of breast cancer Yes No
Family member Yes No
If yes:
Mother ____ Sister ____ Aunt ____ Grandmother ____

Skin Cancer History

Melanoma	Yes	No
Basal Cell	Yes	No
Squamous Cell	Yes	No

Habits and Psychiatric History

Do you drink alcohol? Yes No How much? ____
If no, did you ever? Yes No When did you quit? ___/___/___
Do you smoke? Yes No How much? ____
If no, did you ever? Yes No When did you quit? ___/___/___
Do you use any recreational drugs? Yes No
Marijuana ____ Cocaine ____ Heroin ____ Other ____

Have you suffered from any mental illness? Yes No
Have you ever been hospitalized for a mental illness? Yes No

Menstrual History

Age of first menses _____ Regular _____ Irregular _____
Number of pregnancies _____ Number of miscarriages _____
Number of abortions _____ Number of children _____
Birth control pills _____ Other contraceptive therapy _____
Hormone therapy _____ Age of menopause _____

Family History

Have any of your close relatives had any of these diseases? (Mother, Father, Sister, Brother, Daughter, Son)

Diabetes _____
Heart Disease _____
Heart Attack _____
Hypertension _____
Stroke _____
Cancer _____ If yes, what type? _____
Bleeding Tendency _____
Anemia _____
Mental Disorder _____

Maximum Weight

Date ___/___/___ Weight ____ Height: Feet ____ Inches ____ BMI ____
EBW 0 to 0 Date of Gastric Bypass: ___/___/___

Current Weight

Date ___/___/___ Weight ____ BMI ____ BSA 0.00
Ideal Body Weight 0 to 0 (BMI 18.50 - 25.00) Schnur 0
EBW 0 to 0 % of EBW Lost 0% to 0%

Medications

Please list all medications you take including prescription medications, birth control, and over the counter medications (i.e. Tylenol, Aspirin, Advil, Motrin, etc.).

Medication	_____	Dosage	_____	How Often?	_____
Medication	_____	Dosage	_____	How Often?	_____
Medication	_____	Dosage	_____	How Often?	_____
Medication	_____	Dosage	_____	How Often?	_____
Medication	_____	Dosage	_____	How Often?	_____
Medication	_____	Dosage	_____	How Often?	_____
Medication	_____	Dosage	_____	How Often?	_____
Medication	_____	Dosage	_____	How Often?	_____
Medication	_____	Dosage	_____	How Often?	_____
Medication	_____	Dosage	_____	How Often?	_____
Medication	_____	Dosage	_____	How Often?	_____

Allergies

Please list all medications and foods that you are allergic to.

Medication	_____	Reaction	_____
Medication	_____	Reaction	_____
Medication	_____	Reaction	_____
Medication	_____	Reaction	_____
Medication	_____	Reaction	_____
Medication	_____	Reaction	_____
Food	_____	Reaction	_____
Food	_____	Reaction	_____
Food	_____	Reaction	_____

Do you have a latex allergy? Yes No
Can you receive blood products? Yes No

Robert B. Nemerofsky, M.D.
Nemerofsky Plastic Surgery Corporation
Plastic and Reconstructive Surgery
Board Certified by the American Board of Surgery
Specializing in Body Contouring

16 Pocono Road, Suite 214
Denville, New Jersey 07834
Office: 973-784-1024
Fax: 973-710-0887
E-mail: DrNemerofsky@optonline.net
Web Page: http://DrNemerofsky.com

1. CONSENT TO TREATMENT / ADMISSION - Please read carefully

I assign and hereby consent to treatment at Nemerofsky Plastic Surgery/Robert Nemerofsky, M.D. and authorize each of its physicians, practitioners, health care professionals, employees and members of its Medical Staff to render medical care. I understand that the medical care that I receive at this facility may include, but not limited to, laboratory tests, diagnostic procedures, therapy, examinations and administration of medications, etc. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury, or even death. I understand and acknowledge that no guarantee have been made to me about the outcome of my care.

I further grant permission for the use of such blood, urine or other bodily fluids, tissues, and other specimens as it may be necessary to remove during an operation, diagnostic or therapeutic procedure, for purposes of pathological diagnosis and thereafter for the advancement of medical science and education, and their disposal in accordance with routine hospital practice and governmental regulations, at this facility or at such other institution as Nemerofsky Plastic Surgery/Robert Nemerofsky, M.D. may designate.

2. RELEASE OF INFORMATION – Please read carefully

I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

3. RELEASE OF INFORMATION – Please read carefully

I hereby authorize Nemerofsky Plastic Surgery/Robert Nemerofsky, M.D. to release part or all of my medical record (as necessary to either determine eligibility for health benefits or verify, collect or pursue my account) to any person, corporation, agency or entity that is either responsible for payment of the cost of care provided to me, or involved in the collection, processing, verification, or payment of my account, regardless of whether I am eligible or reimbursement by a third-party payer. My consent to the release of this information is subject to revocation at any time, except to the extent that the party which is to make the disclosure has already relied upon my consent. **I authorize Nemerofsky Plastic Surgery/Robert Nemerofsky, M.D. to release information to outside healthcare institutions, agencies, or physicians as necessary to maintain continuity of care post discharge. I acknowledge I have been provided Nemerofsky Plastic Surgery, Corporation's "Notice of Privacy Practices" to read, and any questions I had were answered to my satisfaction.**

_____ _____ _____
Signature of Patient or Person Legally Responsible | Relationship to Patient | Date

_____
Printed Name of Patient or Person Legally Responsible

4. ASSIGNMENT OF BENEFITS – Please read carefully

I irrevocably authorize and direct all payments to go directly to Nemerofsky Plastic Surgery/Robert Nemerofsky, M.D. for hospital / medical insurance benefits (from Medicare, Medicaid, commercial insurance, worker's compensation, auto insurance, etc.) that I might be entitled to for the charges of the care / treatment provided to me by Nemerofsky Plastic Surgery/Robert Nemerofsky, M.D. and its employees.

5. FINANCIAL AGREEMENT – Please read carefully

For and in consideration of care and treatment provided, I hereby guarantee payment of all charges not covered or paid by my insurance benefits including Medicare, Medicaid, commercial insurance, worker's compensation, auto insurance, etc. examples of such are any deductibles, co-payment and / or not-covered amounts, etc. Nemerofsky Plastic Surgery is a Medicare Provider and does not participate with any other HMO/POS/PPO, commercial or private insurance carriers. As a courtesy we will forward your claim to your insurance carrier, however, ultimately payment is your responsibility. I hereby agree to all precertification requirements as stated in my health insurance policy. I understand that if the insurance company pays me directly for services provided by Nemerofsky Plastic Surgery/Robert Nemerofsky, M.D. or its employees, it is my responsibility to endorse the payment to Nemerofsky Plastic Surgery/Robert Nemerofsky, M.D. and forward payment. I understand that if I do not pay those amounts which are my responsibility to pay, I will also be responsible for any additional fees (up to 35%) incurred during the collection process, including the collection agency fee and legal fees.

_____ _____ _____
Signature of Patient or Person Legally Responsible | Relationship to Patient | Date

_____
Printed Name of Patient or Person Legally Responsible

_____
Witness

☐ **I have received a copy of this notice.**