

JOSHUA A.KING, M.D.
ALBANY PLASTIC SURGEONS, PLLC
4 Executive Park Drive – Albany NY 12203 – (518) 438-1434
PATIENT INFORMATION FORM

Today's Date: _____

PERSONAL INFORMATION

First Name: _____ Last Name: _____ MI: _____

Address: _____

City: _____ State/Province: _____ Zip Code: _____

Country (If outside US): _____ Date of Birth: _____

Phone 1: _____ Phone 2: (Cell?) _____

Mailing Address (if different from above): _____

City: _____ State/Province: _____ Zip Code: _____

Social Security Number: _____ Sex: Male _____ Female: _____

Marital Status: Married: _____ Single: _____ Divorced: _____ Widowed: _____

Employer: _____ Occupation: _____

Employer Phone: _____ Email: _____

Are You Currently Working? : Yes No

Pharmacy: _____ Phone: _____

Race: Caucasian: _____ Black: _____ Hispanic: _____ Asian: _____ Other: _____

INSURANCE INFORMATION (Please provide all current insurance cards at registration)
(If your insurance requires a referral, please bring this with you and give to the front desk at the time of your appointment)

Primary Insurance company: _____ Is this a Medicare HMO? _____

Policyholder's Name: _____ Relationship: _____ Date of Birth: _____

Group Number: _____ ID Number: _____

Secondary Insurance company: _____

Policyholder's Name: _____ Relationship: _____ Date of Birth: _____

Group Number: _____ ID Number: _____

PHYSICIAN INFORMATION:

Primary Care Physician: _____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

Or Referred by: Website: _____ Friend/relative: _____ Our patient: _____

PATIENT'S NAME: _____ DOB: _____

PATIENT'S MEDICAL HISTORY

CONDITION	YES	NO	*SPECIFY - Use additional space at bottom of page
Myocardial Infarction (Heart Attack)			
Shortness of breath			
Hypertension (high blood pressure)			
Congestive Heart Failure			
Chest Pain / Other Heart Problems			
Seizures / fits / Epilepsy			
Lightheadedness/Passing out			
Problems with Anesthesia			
Do you have a history of drug or alcohol dependency?			
Hearing Loss			
Vision Problems			
Blood Clots			
Peripheral Vascular Disease			
Stroke/Other Vascular conditions			
Hepatitis/Jaundice			
Heartburn / Gastric Reflux			
Diabetes			
Gastrointestinal/Stomach/Bowel Problems			
Arthritis			
Asthma / Emphysema			
Other respiratory problems			
Headaches			
Previous Blood Transfusions			
Thyroid			
Urinary Problems /Kidney Stones			
Hematological (Blood conditions)			
Bleeding / Easy Bruising			
Psychological/Psychiatric			
Neurologic problems			
Back Pain			
Healing / Scar Problems			
Serious Infections			
*ALLERGIES TO MEDICATIONS AND TYPE OF REACTION-PLEASE LIST			
LATEX ALLERGY?			
*OTHER ALLERGIES & REACTION			
*COMMENTS/OTHER CONCERNS:			

PATIENT'S NAME: _____ DOB: _____

EMERGENCY CONTACT INFORMATION

SPOUSE/SIGNIFICANT OTHER CONTACT INFORMATION

Name: _____

Address (if different from patient) _____

City: _____ State/Province: _____ Zip Code: _____

Country (If outside US): _____ Home phone: _____

Cell phone: _____ Date of Birth: _____

Employer: _____ Occupation: _____

Other Relative Emergency Contact:

Name of nearest relative: _____ Relationship: _____

Home phone: _____ Work Phone: _____

Cell phone: _____

Are You Interested In Other Procedures To Enhance Your Appearance? Yes ____ No ____

Examples:

- | | | | |
|------------------------|---------------------|------------------|-------|
| Botox | Restylane / Fillers | Breast Reduction | Other |
| Eyelid Lift / Browlift | Face Lift | Liposuction | |
| Tummy Tuck | Breast Augmentation | Breast Lift | |

Please Explain:

Reviewed by: _____ *Date:* _____

INSURANCE AUTHORIZATION

I, _____ authorize the release of any medical information necessary to process my insurance claims. I request that all payments be made on my behalf and that all benefits be assigned for physician services to “*Albany Plastic Surgeons, PLLC*”. I authorize this request to apply to all services provided after the date below. I understand that I am responsible for payment of any balance not paid by my insurance company, as outlined in my schedule of benefits and as applicable under the law.

I also give permission for the use of any non-identifying photographs of this case for review, in medical lectures or publications. I give permission for peer physicians to review my chart to obtain information about the delivery of medical care in order to provide high quality patient care in this office.

Patient Name

Date: _____

Patient Signature

Thank you for your time and energy spent in completing this form. It will help us to better care for you.