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: ___________

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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: _______________________________________

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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			
Chronic Hoarseness			
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:** _____________________

ABOUT YOU: **HEIGHT:**_______________ **WEIGHT:**___________________

Have you ever smoked? ______ If so, how many packs per day _________ for ________ years

Current smoker? _______________

Do you exercise? ______________ How often? ____________________/month

Do you drink alcohol? __________ How much? ____________________/month

Do you drink coffee? ___________ How much? _____________________/month

Do you use recreational drugs? _____ How much? ___________________/month

Have you ever taken steroids? _______________

When was your last physical exam? ____________ By whom?_______________

Have you ever been tested for sickle cell? Yes ____ No _______ Unsure _____

If yes, result? __________ (positive/negative/not sure)

Have you ever been tested for tuberculosis? Yes ____(date of test) No _____ Unsure _____

If yes, result? _________ (positive/negative/not sure)

FOR WOMEN ONLY:

Have you ever been pregnant? ___________ Are you pregnant? ___________

Number of children _______ Age(s) ______Number of children breastfed ___________

Date of last menstrual cycle: ______________ PAP smear in the last three years? ___________

Do you do self breast exams? _____________

FOR PATIENTS LESS THAN 15 YEARS OLD:

Prematurity? ____________________ Up to date with Immunizations?: __________________

PAST SURGERIES, ACCIDENTS AND HOSPITALIZATIONS

Surgery/Hospitalization	Reason	Date (mm/dd/yyyy)

PATIENT'S NAME: ____ DOB: _____________________

FAMILY HISTORY

Condition	Mother Living / Deceased	Father Living / Deceased	Blood Relative
Allergies			
Asthma			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Lung Disease			
Malignant Melanoma			
Skin Cancer			
Tuberculosis			

CURRENT MEDICATIONS, OVER THE COUNTER MEDICATIONS, VITAMINS AND HERBS

MEDICATION	DOSAGE (Mgs)	TIMES PER DAY

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: ___________________________________

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Other Relative Emergency Contact:

Name of nearest relative: ______________________________ Relationship: ___________________________

Home phone: _________________________________Work Phone: _________________________________

Cell phone: ____

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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:

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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.

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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.