Name:_____ Date of Birth: ____/____/____ Age _____ Sex: M F

Home #:_____Work #:_____Cell #:_____ Email Address:_____

Address:_____ City:_____ State:_____ Zip:_____

SS#:_____—_____—_____ Marital Status: M D S W Sep.

Reason for Consultation:_____ **Date of Injury** (if applicable)_____/_____/_____

Have you consulted other Doctors about this? Yes(recently)____ Yes(a while ago)____ No____

How did you **first** hear about our office? Word of Mouth/Patient Referral _____ Name (if known) _____

Physician Referral _____ Internet Search ____ Other _____

Occupation:_____ Employer:_____

Spouse's Name:_____ Spouse's Occupation:_____

Spouse's Employer:_____ Spouse's Work #:_____

Emergency Contact:_____ Relationship:_____ Home #:_____ Work:_____

I do____ I do not____ have Advance Directives. **(It is your responsibility to provide a copy of your advance directive to the Surgery Center prior to procedure.)**

Family Doctor:_____ Phone #:_____

Name of Primary Insurance Company_____ Effective Date:_____

Primary Insurance ID #:_____ Group #::_____

Subscriber Name:_____ Relationship:_____

SS #:_____-____-_____ Date of Birth:____/____/____ Employer:_____

Referral required? Yes____ No____ Referring Physician:_____

Name of Secondary Insurance Company_____ Effective Date:_____

Secondary Insurance ID #:_____ Group #::_____

Subscriber Name:_____ Relationship:_____

SS #:_____-____-_____ Date of Birth:____/____/____ Employer:_____

Insurance Address (if not on card):_____

Release of Information

I certify that the information I have reported with regard to my insurance coverage is correct. I authorize the release of any necessary information, including medical information to my insurance carrier, Medicare, and or Medical Service of Maryland.

Assignment of Benefits

I request the payment of benefits (Medicare, or other insurance carriers) be made directly to The Plastic Surgery Center of Maryland, P.A. and/or Surgical Specialty Suites, Inc. for services rendered to me by Adam L. Basner, M.D., Lawrence I. Rosenberg, M.D. and/or Michele A. Shermak , M.D. I authorize Adam L. Basner, M.D., Lawrence I. Rosenberg, M.D., and/or Michele A. Shermak, M.D. to apply for benefits on my behalf.

_____

Signature Date

OVER TO COMPLETE FORM

Do you **currently have or do** you **have a history of:**

Chest Pain	Yes____ No____	Dry Eyes	Yes____ No____
Heart Attack	Yes____ No____	Kidney Disease	Yes____ No____
Heart Surgery	Yes____ No____	Auto Immune Disorder	Yes____ No____
Heart Failure	Yes____ No____	Bruise / Bleed Easily	Yes____ No____
Sleep Apnea/CPAP	Yes____ No____	Breast Problems	Yes____ No____
Latex Allergy	Yes____ No____	**Family History** of Breast Cancer	Yes____ No____
Heart Disease	Yes____ No____	Glaucoma	Yes____ No____
High Blood Pressure	Yes____ No____	Laser Vision Surgery	Yes____ No____
Murmur or Mitral Valve Prolapse	Yes____ No____	Forming Keloids	Yes____ No____
Lung Disease	Yes____ No____	Mental or Nervous Condition	Yes____ No____
Asthma	Yes____ No____	Allergic to Adhesive Tape	Yes____ No____
Emphysema	Yes____ No____	Cold Sores	Yes____ No____
Diabetes	Yes____ No____	Smoking	Yes____ No____
DVT or Blood Clots/Clotting Disorder	Yes____ No____	Do you smoke now?	Yes____ No____
Family History of DVT/Blood Clots/Clotting Disorder	Yes____ No____	Packs Per Day_____	

Other Important Medical Problems:_____

_____

Current Medications (List **all** medications you are currently taking to include: blood thinners, aspirin, birth control pills, diuretics, blood pressure or heart medications, tranquilizers, hormones, diet suppressants, accutane, glucophage, etc.)

Medication *Reason for taking medication*

_____

_____

_____

_____

Do you take any hormone replacement / birth control? Yes____ No____ If yes, type:_____

Do you take any *herbs* or *dietary supplements?* Yes____ No____ If yes, type:_____

Allergy to Latex: Yes____ No____

Allergies to Medications: Yes____ No____ If Yes, list medications and reactions:_____

_____

Previous Surgery

Operation *Year* *Hospital* *Surgeon* *Type of Anesthesia*

_____

_____

_____

_____

_____

Complications after surgery? Yes____ No____ If Yes, Explain:_____

Number of Childbirths _____ Number of C-Sections_____

Medical History

Height_____ Weight_____

Date of most recent: Mammogram____/____/____ Results: Normal_____ Abnormal_____

Date of most recent: Physical Exam_____ EKG_____ Chest x-ray_____

Health: Good____ Fair____ Poor____ If not Good, explain:_____

_____