PREMIER PLASTIC SURGERY CENTER OF NEW JERSEY

310 MADISON AVENUE, SUITE 100, MORRISTOWN, NJ 07960
PHONE #: (973)889-9300
FAX#: 973-889-9400

Patient Information as of _____
(todays date).

Please print legibly and indicate an answer to all questions.

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home #: _____ Cell #: _____ Email: _____

Birthdate _____ SS# _____-_____-_____ Gender: ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: _____ ❒ Other: _____

Patient's Employer _____ Occupation _____

Work #: _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
City State Zip

Emergency Contact _____ Relationship to Patient _____

Home #: _____ Cell #: _____ Other #: _____

Medications and Allergies

Pharmacy: _____ Phone: _____

Are you currently taking aspirin? □ No □ Yes If "Yes" : □ 81 mg (baby) □ 325 mg

Usage non-steroidal anti-inflammatory drugs (ex. Motrin, Aleve, Tylenol):

□ Daily □ Occasionally □Weekly □ Rarely □Never

Coumadin use: □ No □ Yes

Are you currently taking medications, vitamins or supplements? □ No □ Yes

If you answered "Yes", please list below:

Medication	Dosage	Supplements	Dosage

Are you allergic to latex? □ No □ Yes

Are you allergic to nickel? □ No □ Yes □ Not Sure

Do you have any allergies? □ No □ Yes

If you answered "Yes", please list your allergies: _____

_____

_____.

Medical History

This Medical History Form is part of a Confidential Medical Record and will not be released unless you have authorized us to do so. The information contained in this form will be used by Dr. Glatt in decisions regarding your medical care and treatment. Please answer all questions to the best of your knowledge.

Name: _____ DOB: _____ Today's Date: _____

Height: _____ Weight: _____ Date of Last Physical Exam: _____

Primary Physician: _____Phone: _____

Address: _____

Please check any conditions below that you have or had in the past (indicate date(s) of occurrence).

- □ Blood Clots in your legs _____
- □ Blood Clots in your lungs_____
- □ Diabetes _____
- □ Tuberculosis _____
- □ Arthritis _____
- □ Hypertension _____
- □ CAD (Coronary Artery Disease)_____
- □ Hypercholesterol _____
- □ Heart Attack _____
- □ Congenital Heart Disease _____
- □ Rheumatic Heart Disease _____
- □ Hepatitis _____
- □ Stomach Ulcers _____
- □ Colitis _____
- □ Goiter/Thyroid Disease _____
- □ Hyperthyroidism _____
- □ Hypothyroidism _____
- □ Pneumonia _____
- □ Bronchitis _____
- □ Bleeding Tendency _____
- □ Migraine Headaches_____
- □ Epilepsy _____
- □ Stroke _____
- □ HIV+ _____
- □ Cold Sores/Fever Blisters _____
- □ Herpes _____ □ Genital _____
- □ Cancer _____
- □ Kidney Disease _____
- □ Please list other not on list:_____
- □ No medical issues.

Do you have any children? □ No □ Yes

If yes, what are their ages:_____

Have you ever smoked cigarettes? □ No/Never □ Yes

If yes, currently, how many per day?_____For how long?_____

If you previously smoked and have quit, when did you quit?_____

Alcohol usage: □ No □ Yes

If yes, what type and how much?_____

Do you use/have you used recreational drugs? □ No □ Yes

If yes, what and how often? _____

Have you ever had treatment by a counselor, psychiatrist or psychologist? □ No □ Yes

If yes, when and for what condition? _____

Were you prescribed any medication as part of this treatment? □ No □ Yes

If yes, list medication(s) prescribed: _____

Do you have any implants/artificial limbs/prostheses?

If yes, where?_____

Do you have a pacemaker or Automatic Implantable Cardioverter Defibrillator(AICD)? □ No □ Yes

List name and date of ANY surgery you have had: _____

_____

_____.

Have you ever had an adverse reaction to anesthesia/surgery? □ No □ Yes

If yes, explain:_____.

Women Only

Hormone Replacement Therapy? □ Never Taken □ Current Usage □ Taken in Past

Oral Contraceptives? □ Current Use □ Past Usage □ Never Used

Date of most recent mammogram? _____

Are you still having regular monthly menstrual periods? _____

Have you ever had a discharge from the nipple of your breast? □ No □ Yes - When?_____

Do you regularly have PAP smears? □ No □ Yes - If yes, date of last test? _____

How many pregnancies? _____ Cesarean deliveries? _____

What are the ages of your children? _____

Are you planning on having more children? □ No □ Yes

Sign Below

I certify that the medical information I have provided is accurate and complete to the best of my knowledge.

_____

Signature Date

Office Policies

Patient Name:

- Privacy Policy

The privacy of your medical information is of the utmost importance to our practice. We adhere to all laws governing protection of your medical information as outlined in the Health Insurance Portability and Accountability Act of 1996. You may obtain a copy of our Privacy Policy at the time of your visit to our office. It may be necessary to release your protected health information to banks, insurance companies, financing companies and/or credit card entities to facilitate your payment. By initialing below I consent to allow Premier Plastic Surgery Center of New Jersey to use and disclose this information to the above named entities when such information is requested to process a payment.

Initial: _____

- Financial Policy Summary

Office visits are payable on the day of service. For your convenience, we accept American Express, Discover, MasterCard, Visa, checks and cash. Any returned check will incur a bank fee charge. Unpaid accounts are subject to collection fees up to 50% of the outstanding balance. Credit Card refunds incur a 3% service charge.

Dr. Glatt participates in Atlantic Health System PPO. If you have insurance other than this you will be utilizing your out of network benefits. As a courtesy we will submit insurance claims on your behalf; however any balance remains your responsibility. A copy of our complete Financial Policy is available at our office and will be provided to you upon request.

Initial :_____

- Communication

May we send mail to your home address? Yes □ No □

May we contact you via email? Yes □ No □

May we contact you via text message? Yes □ No □

Initial:_____

My signature below certifies that I have read, understand and agree to the above policies.

Signature: _____ Date: _____